Supreme Court, U.S.
FILED

(1)

No. 02 469 SEP 19 2002

OFFICE OF THE CLERK

In The

# Supreme Court of the United States

THE BLACK & DECKER DISABILITY PLAN,

*Petitioner,*

v.

KENNETH L. NORD,

*Respondent.*

**On Petition For Writ Of Certiorari To The United States Court Of Appeals For The Ninth Circuit**

## PETITION FOR WRIT OF CERTIORARI

WINSTON & STRAWN
LEE T. PATERSON
*Counsel of Record*
AMANDA C. SOMMERFELD
333 South Grand Avenue, 38th Floor
Los Angeles, California 90017-1543
Phone: (213) 615-1700
Fax: (213) 615-1750

*Attorneys for Petitioner*
*The Black & Decker Disability Plan*

COCKLE LAW BRIEF PRINTING CO. (800) 225-6964
OR CALL COLLECT (402) 342-2831

126 PP

## QUESTION PRESENTED

Whether the Ninth Circuit erred in holding that an ERISA disability plan administrator's determination of disability is subject to the "treating physician rule" and, therefore, the plan administrator is required to accept a treating physician's opinion of disability as controlling unless the plan administrator rebuts that opinion in writing based upon substantial evidence on the record.

## LIST OF PARTIES

The parties to the proceeding below are the Petitioner-Defendant, The Black & Decker Disability Plan and the Respondent-Plaintiff, Kenneth L. Nord. There are no other parties.

## RULE 29.6 STATEMENT

Petitioner is not a corporation, it is a funded benefit plan sponsored by Black & Decker (U.S.) Inc., which is a wholly owned subsidiary of The Black & Decker Corporation, which is a publicly held corporation.

## RELATED CASES

The United States Court of Appeals for the Ninth Circuit decision in this case was based upon its previous decision in *Delta Family-Care Disability and Survivorship Plan v. Frank Regula*, No. 81-1840, which is before this Court on a Petition for a Writ of Certiorari.



## TABLE OF CONTENTS


| | Page |
|---|---|
| QUESTION PRESENTED | i |
| LIST OF PARTIES | ii |
| RULE 29.6 STATEMENT | ii |
| RELATED CASES | ii |
| PETITION FOR WRIT OF CERTIORARI | 1 |
| OPINION BELOW | 1 |
| STATEMENT OF JURISDICTION | 1 |
| STATUTES AND REGULATIONS INVOLVED | 1 |
| STATEMENT OF THE CASE | 2 |
| I. THE CLAIM AND APPEALS PROCESS AND THE PLAN'S DECISION-MAKING AUTHORITY | 3 |
| A. Respondent's Back Injury | 4 |
| II. DISTRICT COURT DECISION | 7 |
| III. NINTH CIRCUIT DECISION | 8 |
| REASONS FOR GRANTING THE PETITION | 9 |
| I. THIS PETITION SHOULD BE GRANTED TO RESOLVE CONFLICTING DECISIONS BETWEEN THE SECOND, THIRD, FOURTH, EIGHTH, NINTH, AND ELEVENTH CIRCUIT COURTS OF APPEALS | 13 |
| A. THE NINTH CIRCUIT CASES | 14 |
| B. THE SECOND, THIRD, FOURTH, FIFTH, SEVENTH AND ELEVENTH CIRCUIT CASES | 15 |

TABLE OF CONTENTS – Continued

Page

C. THE EIGHTH CIRCUIT DECISIONS..... 19

II. THE PETITION SHOULD BE GRANTED TO RESOLVE CONFUSION IN THE DISTRICT COURTS ..... 20

CONCLUSION ..... 23



TABLE OF AUTHORITIES

Page

CASES

*Coker v. Metropolitan Life Ins. Co.*, 281 F.3d 793 (8th Cir. 2001) .....20

*Conley v. Pitney Bowes*, 176 F.3d 1044 (8th Cir. 1999).....19

*Conners v. Connecticut General Life Ins. Co.*, 272 F.3d 127 (2nd Cir. 2001).....15

*Delta Family-Care Disability and Survivorship Plan v. Marshall*, 258 F.3d 834 (8th Cir. 2001) .....19, 21

*Delta Family-Care Disability and Survivorship Plan v. Frank Regula*, No. 81-1840..... ii

*Donaho v. FMC Corp.*, 74 F.3d 894 (8th Cir. 1996) .....19

*Dray v. Railroad Retirement Bd.*, 10 F.3d 1306 (7th Cir. 1993).....12

*Durr v. Metropolitan Life Ins. Co.*, 15 F. Supp. 2d 205 (D. Conn. 1998).....20

*Edgerton v. CNA Ins., Inc.*, No. 01-2597, 2002 U.S. Dist. LEXIS 15490 (PA Aug. 6, 2002).....11

*Egelhoff v. Egelhoff*, 532 U.S. 141 (2001) .....10

*Ehrensaft v. Dimension Works, Inc. Long Term Disability Plan*, No. 01-15062, 2002 U.S. App. LEXIS 7876 (9th Cir. 2002) (unpublished).....15

*Elliott v. Sara Lee Corp.*, 190 F.3d 601 (4th Cir. 1999).....17

*Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101 (1989)..... 7

*Fletcher-Merrit v. NorAm Energy Corp.*, 250 F.3d 1174 (8th Cir. 2001).....19

TABLE OF AUTHORITIES – Continued

Page

*Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1 (1987) ..... 10

*Jackson v. Metropolitan Life*, 24 Fed. Appx. 290, 2001 U.S. App. LEXIS 23792 (6th Cir. 2001) (unpublished) ..... 14

*Jett v. Blue Cross and Blue Shield of Alabama, Inc.*, 890 F.2d 1137 (11th Cir. 1989) ..... 18

*Lamoreaux v. Medtronic, Inc.*, No. 1:01-CV-179, 2001 U.S. Dist. LEXIS 13625 (W.D. Mich. 2001) ..... 20

*Nord v. Black & Decker Disability Plan*, 296 F.3d 823 (9th Cir. 2002) ..... 15, 22

*Olive v. Am. Express Long Term Disability Benefit Plan*, 183 F. Supp. 2d 1191 (C.D. Cal. 2002) ..... 15

*Regula v. Delta Family-Care Disability Survivorship Plan*, 266 F.3d 1130 (9th Cir. 2001) ..... 9, 11, 12, 14, 22

*Rush Prudential HMO, Inc. v. Moran*, 122 S. Ct. 2151, 153 L. Ed. 2d 375 (2002) ..... 9, 22

*Sally v. E.I. Dupont de Nemours & Co.*, 966 F.2d 1011 (5th Cir. 1992) ..... 11, 17

*Sheppard & Enoch Pratt Hospital, Inc. v. Travelers Insurance Co.*, 32 F.3d 120 (4th Cir. 1994) ..... 17

*Skretvedt v. E.I. Dupont De Nemours & Co.*, 268 F.3d 167 (3d Cir. 2001) ..... 16

*Soltysiak v. Unum Provident Corp.*, No. 2:01-CV-15, 2002 U.S. Dist. LEXIS 238 (W.D. Mich. 2002) ..... 20

*Stephens v. Heckler*, 766 F.2d 284 (7th Cir. 1985) ..... 11

*Tremain v. Bell Industries*, 196 F.3d 970 (9th Cir. 1999) ..... 7



TABLE OF AUTHORITIES – Continued

Page

*Turner v. Delta Family-Care Disability and Survivorship Plan*, 291 F.3d 1270 (11th Cir. 2002) ..... 18, 21

*U.S. v. Franklin*, 250 F.3d 653 (8th Cir. 2001) ..... 19

*Varity Corp. v. Howe*, 516 U.S. 489 (1996) ..... 9

*Webster v. Black & Decker (U.S.), Inc.*, No. 01-1946, 2002 U.S. App. LEXIS 6574 (4th Cir. 2002) (unpublished) ..... 17, 22

*Wilczynski v. Kemper Nat'l Ins. Co.*, 178 F.3d 933 (7th Cir. 1999) ..... 18

STATUTES AND RULES

*Benefit Claims Procedure Regulation* Questions

28 U.S.C. Section 1254(1) ..... 1

29 U.S.C. Section 1132(a)(1)(B) ..... 7

United States Department of Labor, Employee Retirement Income Security Act of 1974 (ERISA) ..... *passim*

## PETITION FOR WRIT OF CERTIORARI

Petitioner-Defendant, The Black & Decker Disability Plan, respectfully petitions for a writ of certiorari to review the July 15, 2002, decision of the United States Court of Appeals for the Ninth Circuit in the above-entitled proceeding finding that the plan administrator of an ERISA controlled disability plans must apply the "treating physician rule" when reviewing a request for disability benefits and that failure to use the "treating physician rule" is evidence of a conflict of interest.

## OPINION BELOW

The opinion of the United States Court of Appeals for the Ninth Circuit reversing the decision of the United States District Court for the Central District of California and the opinion of the United States District Court for the Central District of California are reproduced in the Appendix.

## STATEMENT OF JURISDICTION

The judgment of the Circuit Court of Appeals was entered on July 15, 2002. This Petition for a Writ of Certiorari is filed within 90 days of that date. This Court's jurisdiction is invoked under 28 U.S.C. Section 1254(1).

## STATUTES AND REGULATIONS INVOLVED

Relevant provisions of the United States Department of Labor, Employee Retirement Income Security Act of

1974, *Benefit Claims Procedure Regulation* Questions, are reproduced in the Appendix,

## STATEMENT OF THE CASE

Respondent was a Material Planner for Kwikset Corporation, a subsidiary of The Black & Decker Corporation. [Appendix, Petitioner's Supplemental Excerpt of Record ("SER") 6] His responsibilities as a Material Planner included ordering goods, interacting with vendors and maintaining inventory levels. [SER 6] His job was sedentary. [SER 8-9] It involved up to six hours of sitting and up to two hours of standing or walking. [SER 154] Respondent's job did not require him to climb, twist, bend over, crouch, stoop, balance, reach above shoulder level, push or pull, grasp, or make repetitive motions with hands or feet. [SER 154] His job description provides that occasionally he was required to carry up to 20 pounds, but never more. *Id.*

As a Kwikset employee, Respondent participated in the company sponsored disability plan ("Plan"). [SER 7] On or about July 15, 1997, Respondent ceased working due to a back injury and submitted a claim for long term disability benefits under the Plan. [SER 7] The Plan provides long term benefits for participants who are disabled from doing their regular job for the Company for the first 30 months of disability, and continuing benefits thereafter for those participants who are disabled from any gainful occupation for which the employee is reasonably qualified. [SER 18, 31]



## I. THE CLAIM AND APPEALS PROCESS AND THE PLAN'S DECISION-MAKING AUTHORITY

The Plan provides:

"The determination of Disability shall be made by the Plan Manager based on suitable medical evidence and a review of the Participant's employment history that the Plan Manager deems satisfactory in its sole and absolute discretion." [SER 31] The Plan also vests the Plan Manager with the authority to delegate one or more of his responsibilities to a Claims Administrator. [SER 38]

On February 16, 1998, MetLife informed Respondent that his claim was denied and that he could "request a review of [his] claim" by sending a request to MetLife's "Group Claims Review." [SER 8] On March 25, 1998, Respondent's counsel sent a letter to MetLife requesting review of the denial. [SER 8,159-160] Between March 25, 1998, and October 14, 1998, Respondent's counsel and MetLife exchanged letters and medical documentation. [SER 44-45, 158-160] On October 15, 1998, and October 21, 1998, MetLife made a recommendation to the Plan Manager to uphold the denial of Respondent's claim and provided the Plan Manager with all of the information upon which it relied in coming to that conclusion. [SER 8, 43, 53] The Plan Manager reviewed the information, conducted a further investigation and agreed with MetLife's recommendation. [SER 8-9] The Plan Manager informed Respondent of the results of the first step of his appeal by letter on October 27, 1998. [SER 9]

### A. Respondent's Back Injury

Respondent's X-rays and MRI's revealed that he has degenerative disc disease, "mild bilateral L5 radiculopathy," but no spinal stenosis or disk herniation and no root compression. [SER 54-56] At Appellee's request, Respondent was examined by Dr. Antoine Mitri, an independent medical examiner. [Respondent's Excerpts from the Clerk's Record, Record 21:BD 0138]

Respondent informed Dr. Mitri that he had experienced chronic low back pain for 15 years. [SER 54] However, this claim was contradicted by his treating physician's records which, though dating back to 1993, first reported back pain only five months prior to his last day at work in 1997. [SER 54-57, 65-76] There is no evidence that Respondent was prescribed pain killers before July 1997. [SER 65-76] The medical records show that Respondent stated that "medication helps" his pain, he "feels worse without medication" but it is "tolerated with medication," and that his "symptoms are controlled with Relafen, occasional Darvocet and Flexeril." [SER 79, 98, 100]

Dr. Mitri's independent medical examination notes, dated July 17, 1998, provide that Respondent had "no limitation" with respect to transportation, standing, sitting, changing positions between standing and sitting, reaching forward and overhead, grasping or handling, finger dexterity, operating electrical equipment and concentrated visual attention. [SER 58] Dr. Mitri notes "some limitation in assuming cramped or unusual positions," twisting, pushing or pulling, repetitive movements, and operating a truck or dolly. *Id.*



Dr. Mitri's report concludes that Respondent suffered from degenerative disc disease and chronic myofascial pain syndrome. [SER 54-56] However, he also concluded that:

> [after] reviewing the patient's job description, and on the basis of the general examination and neurological examination, and after reviewing the report of his test, I think that the patient should be able to do sedentary work with some interruption by walking in between. Accordingly, I do not think the patient is disabled to perform that kind of work even though he is complaining from low back pain [because] all the work up that was done did not really show any evidence to substantiate disability in doing sedentary work with some walking interruption in between. *Id.*

MetLife sent Dr. Mitri's report to Respondent's attorney and asked that he submit the report to Respondent's treating physician and obtain his comment on it. [Respondent's Excerpts from the Clerk's Record 21:BD0134] Respondent never provided his physician's response to Dr. Mitri's opinion, despite a second request. [Respondent's Excerpts from the Clerk's Record 21:BD0131] Instead, Respondent's attorney contacted Janmarie Forward, a Human Resource representative at Kwikset, and requested that she complete a "Work Capacity Evaluation" responding to several of his questions. [SER 46-48] Among the questions he asked her were:

> Dr. Mitri indicates that's [sic] Kenneth Respondent can do sedentary capacity, as long as he can interrupt his sitting by walking in between at will. In your employer statement provided to Metropolitan, you have described the job as requiring sitting

between 5 and 6 hours in a day and standing and walking between 1 and 2 hours in a day. Assume that the need to stand and walk to relieve pain is unpredictable and that when the pain requires walking about, the individual must get up and move.

Could the individual with those limitations perform the work of a material planner?

___yes ___no

Ms. Forward responded "yes." [SER 47-48]

Respondent's counsel also asked the following question:

Dr. Mitri describes Kenneth Respondent as suffering from degenerative disc disease and a chronic myofascial pain syndrome. You have indicated in your employer statement provided to Metropolitan that the work of a material planner requires continuous interpersonal relationships and frequent exposure to stressful job situations. Assume that Kenneth Respondent would have a moderate pain that would interfere with his ability to perform intense interpersonal communications or to act appropriately under stress occasionally (up to one-third) during the day.

Could individual [sic] of those limitations perform the work of a material planner?

___yes ___no

Ms. Forward responded "no." *Id.*

After receiving MetLife's benefit file and MetLife's recommendation that the denial of Respondent's claim be upheld, Ray Brusca, the Plan Manager, telephoned Ms. Forward and investigated her response to the question



concerning whether Respondent could perform his job if his pain "interfere[d] with his ability to perform intense interpersonal communications or to act appropriately under stress." [SER 8-9] After questioning Ms. Forward about the specific responsibilities that Respondent performed and the reason she responded as she did, the Plan Manager agreed with MetLife's conclusion that Respondent was not disabled from performing his own job. [SER 9]

## II. DISTRICT COURT DECISION

Respondent sought review of the Plan Manager's decision by filing a Complaint in the Central District of California under 29 U.S.C. Section 1132(a)(1)(B). At the conclusion of discovery, Petitioner and Respondent made cross motions for summary judgment. The District Court granted Petitioner's motion and denied Respondent's motion. The District Court reviewed the denial of benefits for an abuse of discretion under the standard set forth in *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 115 (1989). [SER 202] In doing so, the District Court rejected Respondent's contention that *de novo* review was appropriate because the Plan Administrator filled the dual role of Plan Administrator and insurer. The District Court held that Respondent had failed to present sufficient evidence that this apparent conflict of interest affected the decision to deny Respondent benefits. [SER 203-4] *See, Tremain v. Bell Industries*, 196 F.3d 970, 976 (9th Cir. 1999) ("If, however, the program participant presents 'material, probative evidence, beyond the mere fact of the apparent conflict, tending to show that the fiduciary's self-interest caused a breach of the administrator's fiduciary obligations to the

beneficiary,' a rebuttable presumption arises in favor of the participant") (internal citation omitted).

The District Court concluded that Respondent did not abuse its discretion in denying Respondent's claim for benefits. The District Court noted that "the mere fact that the plan administrator's decision is directly contrary to some evidence in the record does not show that the decision is clearly erroneous." [SER 204-5] The District Court rejected Respondent's arguments that the decision was "clearly erroneous" because: 1) it was contrary to the opinion provided by a Black & Decker employee that Respondent could not perform his job, if his pain *"interfere[d] with his ability to perform intense interpersonal communications or to act appropriately under stress"*; and 2) it credited the medical opinion of an independent medical examiner over those of Plaintiff's treating physicians. [SER 205-6] The District Court concluded that the company employee's opinion lacked sufficient foundation. [SER 206] It also concluded that the opinions of treating physicians were not entitled to more weight than any other medical opinion. [SER 207] After reviewing the entire administrative record, the District Court concluded that the Plan Manager did not abuse his discretion in denying Respondent's claim for benefits. [SER 208]

## III. NINTH CIRCUIT DECISION

The Ninth Circuit Court of Appeals reversed the District Court's finding that the Black & Decker employee's "opinion" regarding Respondent's ability to perform his job lacked foundation, and held that the Plan's rejection of her opinion was evidence of a conflict of interest which affected the decision to deny benefits. The Ninth



Circuit also relied on its ruling in *Regula v. Delta Family-Care Disability Survivorship Plan*, 266 F. 3d 1130 (9th Cir. 2001), which requires application of the "treating physician rule" to ERISA governed disability plans. Specifically, the Ninth Circuit held that Petitioner's rejection of the conclusions of Respondent's treating physicians without providing "specific, legitimate reasons" based on "substantial evidence in the record" was both evidence of a conflict of interest and a breach of its fiduciary duty to Respondent.

## REASONS FOR GRANTING THE PETITION

This Petition should be granted because there are conflicting decisions between six Circuit Courts of Appeal and there is confusion in the district courts. In addition, this plan like many other ERISA controlled disability plans is national in scope and two circuit courts have issued conflicting decisions as to whether this plan administrator's decisions are subject to the "treating physician rule." The Ninth Circuit's decision forces this plan administrator to use conflicting standards of plan administration based upon the circuit court that has jurisdiction. This conflicts with the ERISA mandate for uniform plan administration. *Rush Prudential HMO, Inc. v. Moran*, 122 S. Ct. 2151, 2169, 153 L. Ed. 2d 375 (2002).

One of the Congressional concerns in drafting ERISA was "not to create a system that is so complex that administrative costs, or litigation expenses, unduly discourage employers from offering welfare benefit plans. . . . " *Varity Corp. v. Howe*, 516 U.S. 489, 497 (1996). One of ERISA's

goals was to " ... establish a uniform administrative scheme. ... " *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 9 (1987). "Uniformity is impossible, however, if plans are subject to different legal obligations in different states." *Egelhoff v. Egelhoff*, 532 U.S. 141, 148 (2001).

ERISA and its Department of Labor ("DOL") regulations are written to provide a balance between plan flexibility and enrollee confidence in disability plans and efficiency in the disability insurance and labor markets. There are no provisions in ERISA which require a plan administrator to use the "treating physician rule." ERISA regulations are written " ... to preserve the greatest flexibility possible for designing and operating claims processing systems consistent with prudent administration of the plan." (*Benefit Claims Procedure Regulation*, Question B-4; *www.dol.gov/pwba*) The DOL has the authority under ERISA to adopt regulations governing the administration of benefit claims for disability plans. While the DOL, as recently as 2001, issued numerous new and revised ERISA regulations, it has never required ERISA disability plan administrators to apply the "treating physician rule."

Most of the "treating physician rule" cases revolve around conflicting stereotypes of benefit plan administrators and physicians. Respondent and the Ninth Circuit Court of Appeals believe that employee plan administrators have an inherent tendency to cheat other employees. Conversely, they believe that treating physicians are inherently credible and that plan administrators should rely upon the physician's obligation to the patient to



insure the physician's credibility[1]. Other Courts of Appeal hold that the treating physician's opportunity to bill for more services creates an inherent conflict of interest and that the plan administrator's obligations as a co-employee and a fiduciary should be relied upon.[2] Most of the decisions ignore the most obvious reason not to trust the treating physician – "physician's bias." To provide proper medical care, a physician has to build trust with her patient. If the patient reports that he cannot work, the physician in an effort to maintain the physician-patient relationship may report that the patient is disabled from work, without considering whether the patient is actually malingering. As stated by the Seventh Circuit in *Stephens v. Heckler*, 766 F.2d 284, 289 (7th Cir. 1985):

> "The patient's regular physician may want to do a favor for a friend and client, and so the treating

---

[1] In *Regula v. Delta Family-Care Disability Survivorship Plan*, 266 F.3d 1130, 1139 (9th Cir. 2001), the Ninth Circuit said that the treating physician: "is employed to cure and has a greater opportunity to know and observe the patient as an individual" (citations deleted); in *Edgerton v. CNA Ins., Inc.*, No. 01-2597, 2002 U.S. Dist. LEXIS 15490 at *22, (PA Aug. 6, 2002), the court stated that, "treating physicians are likely to be the medical professionals most able to provide a detailed, longitudinal picture of [the claimant's] medical impairment(s) and may bring a unique perspective to the medical evidence that cannot be obtained from the objective medical findings alone or from reports of individual examinations, such as consultative examinations or brief hospitalizations."

[2] *See, e.g., Sally v. E.I. Dupont de Nemours & Co.*, 966 F.2d 1011, 1016 (5th Cir. 1992), "We have considerable doubt about holding the rule applicable in ERISA cases. Under it, the treating physician would stand to profit greatly if the court were to find benefits should not be terminated. There is a clear and strong conflict of interest, and we are doubtful that a court should defer automatically to his or her testimony."

> physician may too quickly find disability. The regular physician also may lack an appreciation of how one case compares with other related cases. A consulting physician may bring both impartiality and expertise." (citation omitted.)

All of these stereotypes are poor attempts to generalize a complex subject and should be ignored. Common sense says that some doctors will lie for their patients, others won't; some plan administrators will ignore their fiduciary obligations, others won't. However, no one has any actual or concrete evidence to show that most doctors tell the truth and most employee plan administrators cheat or vice versa. Therefore, a draconian rule that the treating physician's opinion must be given controlling weight belies common sense. Rather the resolution should be left to the entity charged with making the decision – in this case the plan administrator. As stated by the court in *Dray v. Railroad Retirement Bd.*, 10 F.3d 1306, 1311 (7th Cir. 1993), "In the case of dueling doctors, it remains the province of the hearing officer to decide whom to believe – a treating doctor whose experience and knowledge about the case may (or may not) be relevant to understanding the claimant's condition, or a consulting specialist who may bring expertise and knowledge about similar cases."

The Ninth Circuit's holding in *Regula* that there is "no reason why the "treating physician rule" should not be used under ERISA" begs the question. *Regula*, *supra*, 266 F.3d at 1139. The Court's decision is devoid of any legal basis, any factual basis or any public policy reason to infuse the "treating physician rule" into ERISA disability plans. The only policy reason that the decision offers is the limp reasoning that adoption of the rule will provide consistency for the Court to review disability determinations. *Id.*



In other words, courts in the Ninth Circuit will have a lighter workload if the "treating physician rule" is applied to both Social Security disability and ERISA disability determinations.

Employers do not have to provide employee disability plans. One purpose of ERISA was to encourage employers to adopt such plans. The "treating physician rule" takes away employer discretion and forces employers to pay disability benefits even when their plan administrators have an honest and good faith belief that the employee is malingering. Employers, who are convinced their disability plan is being abused by malingering employees, have no incentive to increase plan benefits. Employers without disability plans have no incentive to adopt a plan which they believe will support and encourage malingering. Forcing the "treating physician rule" onto ERISA plan administrators is counterproductive to the basic purposes of ERISA.

## I. THIS PETITION SHOULD BE GRANTED TO RESOLVE CONFLICTING DECISIONS BETWEEN THE SECOND, THIRD, FOURTH, EIGHTH, NINTH, AND ELEVENTH CIRCUIT COURTS OF APPEALS

Currently only the Ninth Circuit Court of Appeals has unequivocally adopted the "treating physician rule" for ERISA disability cases. Four Circuit Courts, the Second, Fourth, Seventh and Eleventh, have unequivocally rejected the "treating physician rule" for ERISA cases. The Third Circuit Court has used the "treating physician rule" as an analogy to support a decision. One Circuit Court, the Fifth, has expressed doubt that the rule applies to ERISA

cases. The Eighth Circuit in an early decision appeared to have adopted the "treating physician rule," but in four subsequent cases has rejected the rule. Another Circuit Court, the Sixth, rejected the "treating physician rule," but did not publish the decision.[3] The First and Tenth Circuits have not ruled on the issue.

### A. THE NINTH CIRCUIT CASES

In the Ninth Circuit case of *Regula v. Delta Family-Care Disability Survivorship Plan*, 266 F.3d 1130 (9th Cir. 2001), a plan administrator terminated the long term disability benefits of an employee. The employee relied upon the opinions of his treating physicians while the plan relied upon the opinions of expert examining physicians. The Ninth Circuit stated that "the treating physician rule can assist courts to enforce the accuracy of disability determinations under ERISA" and therefore found "no reason why the rule should not be adapted" to such cases. *Id.* at 1139. The Court ruling reflects an inherent trust in treating physicians and an inherent mistrust of examining physicians: "far more troubling is the conflict of interest inherent when benefit plans repeatedly hire particular physicians as experts ... these experts have a clear incentive to make a finding of 'not disabled' in order to save their employers money and to preserve their own consulting arrangements." *Id.* at 1143.

Since the decision in *Regula*, courts in the Ninth Circuit have followed the decision. *Nord v. Black & Decker*

[3] *Jackson v. Metropolitan Life*, 24 Fed. Appx. 290, 2001 U.S. App. LEXIS 23792 (6th Cir. 2001) (unpublished).



*Disability Plan*, 296 F.3d 823 (9th Cir. 2002); *Ehrensaft v. Dimension Works, Inc. Long Term Disability Plan*, No. 01-15062, 2002 U.S. App. LEXIS 7876 (9th Cir. 2002) (unpublished); *Olive v. Am. Express Long Term Disability Benefit Plan*, 183 F. Supp. 2d 1191 (C.D. Cal. 2002)

### B. THE SECOND, THIRD, FOURTH, FIFTH, SEVENTH AND ELEVENTH CIRCUIT CASES

The Second Circuit, in *Conners v. Connecticut General Life Ins. Co.* 272 F.3d 127, 135 n. 4 (2nd Cir. 2001) expressly refused to adopt the "treating physician rule." In that case, the employee claimed that he was totally disabled. His treating physicians agreed. However, a reviewing physician found that he was able to perform some work. The court remanded the case to the district court with the following direction:

> "We do not adopt for these purposes – that is, when a district court reviews an ERISA administrator's decision under a de novo standard – the 'treating physician rule,' a standard developed in the Social Security context requiring 'that the fact-finder give greater deference to the expert judgment of a physician who has observed the patient's medical condition over a prolonged period of time."
>
> "As a rule designed to encourage the development of the administrative record so that the district court can determine whether the administrator's decision was supported by substantial evidence, the 'treating physician rule' serves no purpose in the context of de novo review."

*Id.* (citation omitted).

The Third Circuit in *Skretvedt v. E.I. Dupont De Nemours & Co.*, 268 F.3d 167 (3d Cir. 2001) recently used the "treating physician rule" as an analogy for its determination in an ERISA case. In that case, an employee applied for disability benefits. The court found that the employee's disability was supported by all of the treating and examining physicians who provided an opinion. The court then stated:

> "We find it relevant that Drs. Binhammer and Schiff had long-term treatment relationships with Skretvedt and that therefore they were uniquely able to provide detailed longitudinal information on Skretvedt's condition. We have long recognized that in the analogous area of disability benefits determinations under the Social Security Act, the 'opinions of a claimant's treating physicians are entitled to substantial and at times even controlling weight.' *Fargnoli v. Halter*, 247 F.3d 34, 43 (3d Cir. 2001); see also *Cotter v. Harris*, 642 F.2d 700, 704 (3d Cir. 1981); (7th Cir 1985) *Regula v. Delta Family-Care Disability Survivorship Plan*, No. 98-55853, 2001 U.S. App. LEXIS 20851, at *21 (9th Cir. Sept. 24, 2001) (applying the 'treating physician rule,' which requires administrative law judges to defer to a treating physician's opinions when adjudicating Social Security disability benefits, when reviewing an ERISA plan administrator's termination of benefits)." *Id.* at 184.

Since the Court found no conflict among any of the physicians' opinions, it is unclear whether this decision is an adoption by the Third Circuit of the "treating physician rule" or not. However, it is clear that district courts in the Third Circuit and the next Third Circuit panel will have to



decide whether this decision adopts the "treating physician rule" and therefore is binding on them.

The Fourth Circuit has rejected the "treating physician rule" in *Elliott v. Sara Lee Corp.*, 190 F.3d 601, 607-08 (4th Cir. 1999).[4] In *Elliott* the Court reviewed a plan administrator's decision termination of benefits based upon statements of treating and examining physicians' opinions. The plaintiff urged the court to adopt the "treating physician rule" and to base its review on the entire opinion of her physician. The court declined to adopt the "treating physician rule." *See, also, Sheppard & Enoch Pratt Hospital, Inc. v. Travelers Insurance Co.*, 32 F.3d 120, 126 (4th Cir. 1994) (hospital attempting to recover disability plan benefits for a patient's expenses not entitled to invoke the "treating physician rule" "[t]o require the Plan to give conclusive weight to the opinion of the treating physician would deprive it of its role in determining medical necessity").

The Fifth Circuit has expressed doubt that the "treating physician rule" applies to ERISA cases, but has declined to rule. In *Sally v. E.I. Dupont de Nemours & Co.*, 966 F.2d 1011, 1016 (5th Cir. 1992) the court stated:

---

[4] The same plan that is at issue in this case was recently reviewed by the Fourth Circuit in an unpublished opinion in *Webster v. Black & Decker (U.S.), Inc.*, No. 01-1946, 2002 U.S. App. LEXIS 6574 at **14 (4th Cir. 2002) (unpublished). In that case the court reviewed the plan administrator's determination that six treating physicians who found the plaintiff disabled were wrong. The court stated: "We have recognized that it is the Plan Administrator's responsibility to resolve conflicting medical assessments."

> "This Court has not addressed the propriety of the "treating physician rule" in ERISA cases. We have considerable doubt about holding the rule applicable in ERISA cases. Under it, the treating physician would stand to profit greatly if the court were to find benefits should not be terminated. There is a clear and strong conflict of interest, and we are doubtful that a court should defer automatically to his or her testimony." (citation omitted.)

In the Seventh Circuit case of *Wilczynski v. Kemper Nat'l Ins. Co.*, 178 F.3d 933, 938 (7th Cir. 1999), without referring to the "treating physician rule," the court declined to provide any special weight to the opinions of the treating physicians. In that case, an employee with multiple sclerosis was given disability benefits under the company ERISA disability benefit plan. On a review of her continuing disability, the plaintiff offered the opinion of a number of treating physicians and argued that the opinion of treating physicians should control. The plan relied upon the opinions of three examining physicians to terminate her disability benefits. The court held that there was adequate evidence on the record to support the plan administrator's decision.

In the Eleventh Circuit, in the case of *Turner v. Delta Family-Care Disability and Survivorship Plan,* 291 F.3d 1270, 1274 (11th Cir. 2002) the court held that the "treating physician rule" " . . . is contrary to the law of this Circuit" and the administrator could consider all medical reports. *See, also, Jett v. Blue Cross and Blue Shield of Alabama, Inc.*, 890 F.2d 1137, 1140 (11th Cir. 1989).



## C. THE EIGHTH CIRCUIT DECISIONS

One Circuit Court of Appeal, the Eighth, has issued conflicting decisions in regard to applying the "treating physician rule" to ERISA plans.[5] In *Donaho v. FMC Corp.*, 74 F.3d 894, 901 (8th Cir. 1996) the court overturned the plan administrator's decision to terminate disability benefits when it rejected the opinions of two treating physicians and one examining physician in favor of the opinion of a reviewing physician. The court stated: "We have held, in Social Security cases, that a reviewing physician's opinion is generally accorded less deference than that of a treating physician, and we apply this rule in disability cases under ERISA as well." *Id.* (citation omitted). However, the Circuit has rejected the "treating physician rule" in all subsequent cases. *Conley v. Pitney Bowes*, 176 F.3d 1044, 1049 (8th Cir. 1999) (The rule is not that a treating physician's opinion trumps all other evidence, but that a court must give it appropriate weight); *Delta Family-Care Disability and Survivorship Plan v. Marshall*, 258 F.3d 834, 842 (8th Cir. 2001) (a treating physician's opinion does not automatically control, since the record must be evaluated as a whole); *Fletcher-Merrit v. NorAm Energy Corp.*, 250 F.3d 1174, 1180 n.3 (8th Cir. 2001) (a treating physician's opinion does "not automatically

---

[5] The Eighth Circuit has a rule that "one panel cannot overrule another," that is, where a circuit court of appeal panel has issued a decision, subsequent circuit court panels are bound to that opinion until the case is overruled by an *en banc* decision or by a United States Supreme Court case. *See, e.g., U.S. v. Franklin* 250 F.3d 653, 665 (8th Cir. 2001). Whether that rule is intact or has been violated makes little difference to national plan administrators trying to sort out which standard to apply in the Eighth Circuit.

control, since the record must be evaluated as a whole"); *Coker v. Metropolitan Life Ins. Co.*, 281 F.3d 793, 799 (8th Cir. 2001).

## II. THE PETITION SHOULD BE GRANTED TO RESOLVE CONFUSION IN THE DISTRICT COURTS

A number of district courts have reviewed the "treating physician rule" in regard to ERISA plans and have looked to their circuits for usable guidance and found none available. *Durr v. Metropolitan Life Ins. Co.*, 15 F. Supp. 2d 205, 213 (D. Conn. 1998), *Lamoreaux v. Medtronic, Inc.*, No. 1:01-CV-179, 2001 U.S. Dist. LEXIS 13625 at *11-12 (W.D. Mich. 2001). A recent example is *Soltysiak v. Unum Provident Corp.*, No. 2:01-CV-15, 2002 U.S. Dist. LEXIS 238 at *12-14 (W.D. Mich. 2002) where the court stated:

> ". . . in Social Security disability determinations, greater weight is to be given to a treating physician's opinion than the opinions of other doctors. This rule was established because a treating physician is employed to cure not merely to evaluate, has typically been treating a patient over a long period of time, and has a greater opportunity to know the patient than an examining physician who sees the patient on one occasion and whose reports are less thorough. *Id.* The Sixth Circuit has not ruled, however, on the applicability of the 'treating physician rule' to ERISA cases. Other circuits are split. Compare *Regula v. Delta Family-Care Survivorship Plan,* 266 F.3d 1130, 1139 (9th Cir. 2001) (holding that the same rationale for the 'treating physician rule' in Social Security cases applies to ERISA cases as well), *Donaho v. FMC Corp.*, 74 F.3d 894, 901



(8th Cir. 1996) (applying the rule in disability case under ERISA) n.2, with *Sheppard & Enoch Pratt Hosp., Inc. v. Travelers Ins. Co.*, 32 F.3d 120, 126 (4th Cir. 1994) (rejecting the treating physician rule when an ERISA plan administrator is making a determination about the medical necessity of treatment); *Salley v. E.I. DuPont de Nemours & Co.*, 966 F.2d 1011, 1016 (5th Cir. 1992) (expressing "considerable doubt about holding the rule applicable in ERISA cases"); *Jett v. Blue Cross & Blue Shield of Ala., Inc.*, 890 F.2d 1137, 1140 (11th Cir. 1989) (stating that the rule is not applicable to determinations under ERISA-governed plan where treating physician has an economic interest in benefits being paid). One court in this district declined to apply the rule to an ERISA case because the Sixth Circuit has not found that the rule is proper in the ERISA context and because of the potential conflict of interest a treating physician has in benefiting from the continuation of benefits."

The Court should grant this petition. Far too many courts have spent far too much time discussing whether the "treating physician rule" applies to ERISA plans or not. Too many national plan administrators have scratched their heads trying to resolve whether an individual claimant is in a "treating physician rule" jurisdiction or not. Too many court decisions have applied different standards to the same plan. *See, e.g., Turner v. Delta Family-Care Disability and Survivorship Plan,* 291 F.3d 1270, 1273-4 (11th Cir. 2002) ("treating physician rule" does not apply); *Delta Family-Care Disability and Survivorship Plan v. Marshall*, 258 F.3d 834, 843 (8th Cir. 2001) ("treating physician rule" does not apply); and

*Regula v. Delta Family-Care Survivorship Plan,* 266 F.3d 1130, 1139 (9th Cir. 2001) ("treating physician rule" applies); *see, also, Webster v. Black & Decker (U.S.), Inc.*, No. 01-1946, 2002 U.S. App. LEXIS 6574, at **14 (4th Cir. 2002) (unpublished) ("treating physician rule" does not apply); and *Nord v. The Black & Decker Disability Plan,* 296 F. 3d 823 (9th Cir. 2002) ("treating physician rule" applies).

The issues are clear. Either plan administrators are to be trusted and given flexibility to do their jobs or not. Either treating physicians are to be given predominance in determining disability or they are not. Either employers are going to be encouraged to fund disability plans by allowing permissive administration or they are not. Either there are going to be uniform national standards for review of ERISA plan claims, as stated in *Rush Prudential HMO, Inc. v. Moran,* 122 S. Ct. 2151, 2169, 153 L. Ed. 2d 375 (2002), or there will continue to be inconsistent standards applied throughout the United States. Granting this Petition will bring resolution to an issue which has plagued and, unless resolved, will plague the Circuit and District Courts for years.



## CONCLUSION

Petitioner respectfully requests that this Court grant the Petition, on this important issue, to resolve the conflicts within individual circuits and between the circuits.

Respectfully submitted,

WINSTON & STRAWN
LEE T. PATERSON
AMANDA C. SOMMERFELD
333 South Grand Avenue, 38th Floor
Los Angeles, California 90017-1543
Phone: (213) 615-1700
Fax: (213) 615-1750

*Attorneys for Petitioner*
*The Black & Decker*
*Disability Plan*

**FOR PUBLICATION**

# UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

| | |
|---|---|
| KENNETH L. NORD,<br>*Plaintiff-Appellant*,<br>v.<br>THE BLACK & DECKER DISABILITY PLAN,<br>*Defendant-Appellee*. | No. 00-55689<br>D.C. No. CV-99-00408-CM<br>OPINION |

Appeal from the United States District Court
for the Central District of California
Carlos R. Moreno, District Judge, Presiding

Argued and Submitted
October 16, 2001 – Pasadena, California

Filed July 15, 2002

Before: Betty Binns Fletcher, Dorothy W. Nelson, and M. Margaret McKeown, Circuit Judges.

Opinion by Judge B. Fletcher

---

## COUNSEL

Lawrence D. Rohlfing, Esq., Santa Fe Springs, California, for the plaintiff-appellant.

Lee T. Paterson, Esq., Los Angeles, California, for the defendant-appellee.

---

## OPINION

B. FLETCHER, Circuit Judge:

This case arises under the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1001, *et seq*. Plaintiff Kenneth Nord seeks disability welfare benefits from defendant Black & Decker Disability Benefits Plan ("Black & Decker" or the "Plan"). The district court granted summary judgment in favor of Black & Decker, holding that it did not abuse its discretion by denying Nord disability benefits under the terms of the Plan. Nord appeals. We have jurisdiction pursuant to 28 U.S.C. § 1291. Based on our recent decision in *Regula v. Delta Family-Care Disability Survivorship Plan*, 266 F.3d 1130 (9th Cir. 2001), we conclude that the district court erred in reviewing the disability determination for an abuse of discretion. We review *de novo* and reverse.

## FACTUAL AND PROCEDURAL BACKGROUND

Kenneth Nord was formerly employed as a Material Planner for Kwikset Corporation, a subsidiary of the Black & Decker Corporation. Nord's responsibilities as a Material Planner included ordering goods, interacting with vendors, and maintaining inventory levels. The position is a sedentary one, requiring up to six hours of sitting and up to two hours of standing or walking per day.

Through his employment at Kwikset, Nord was enrolled in the Black & Decker Disability Plan. The language of the Plan grants absolute discretion to the Plan



Manager to make disability determinations.[1] The Plan also invests the Plan Manager with the authority to delegate one or more of his responsibilities to a Claims Administrator. The third-party Claims Administrator retained while Nord's claim was under review was Metropolitan Life Insurance Company ("MetLife"). The Plan provides long-term benefits coverage for participating employees who are prevented by disability from occupying their regular jobs for the first 30 months of the disability. At issue here is Nord's disability from performing his regular job for 30 months. Continuing benefits are available for those participants who are prohibited from engaging in any gainful employment for which they are qualified due to their disabilities.[2]

In March 1997, Nord consulted Dr. Hartman regarding his experience with intermittent hip and low back pain. Dr. Hartman concluded that Nord suffered from mild degenerative disc disease at the L4-L5 and L5-S1 vertebral

---

[1] The Plan provides that:

> The determination of disability shall be made by the Plan Manager based on suitable medical evidence and a review of the Participant's employment history that the Plan Manager deems satisfactory in its sole and absolute discretion.

[2] The Plan defines "disability" to mean:

> the complete inability (whether physical and/or mental) of a Participant to engage in his regular occupation with the Employer (during the first 30 months of Disability), and became with the thirty-first month of Disability, the Participants [sic] complete inability (whether physical and/or mental) of a participant to engage in any gainful occupation or employment with any employer for which the Employee is, as of his Disability Date, reasonably qualified by education, training or experience.

levels.[3] In July 1997, Dr. Hartman diagnosed Nord as suffering from sciatica and disc disease at L4-L5 and placed him on medication. After a one-week trial with that treatment plan, Dr. Hartman concluded that Nord had experienced no improvement, and he took Nord out of work temporarily. He recommended orthopedic consultation while continuing medication. On July 16, 1997, Nord submitted a claim under the Plan for up to 30 months of long-term disability benefits.

On August 13, 1997, Dr. Hartman drafted a letter indicating that Nord was under his medical care and would be unable to return to work until he experienced sufficient recovery from his lumbar disc syndrome. Dr. Hartman wrote an additional letter in March 1998, after Nord had begun treatment by an orthopedist, Dr. Lytton Williams, confirming continuing medical treatment and restating his earlier conclusion that Nord remained unable to return to work. In April 1998, Dr. Hartman performed a physical capacity evaluation in which he estimated that Nord could sit for up to one hour a day and could occasionally lift up to five pounds.[4] Nearly identical findings were made by Nord's treating orthopedic physician, Dr. Williams, around the same time.

[3] This diagnosis was later reconfirmed by an MRI scan, conducted on July 23, 1997, which showed degenerative disc disease at L4-L5 and L5-S1, with disc desiccation and a mild diffuse bulge.

[4] At the same time, Nord underwent overlapping treatment from two orthopedic doctors, Dr. Silva and Dr. Mumtaz Ali. Both doctors confirmed aspects of Dr. Hartman's diagnosis, including the presence of lumbosacral pain requiring continued treatment with medication and physical therapy.



On February 16, 1998, MetLife informed Nord that his claim had been denied because he did not meet the "own occupation" definition of disability for the first 30 months of coverage. In the same letter, MetLife also informed Nord that he could "request a review of [his] claim" by sending his request to MetLife's "Group Claims Review." Nord requested review of his claim through a letter sent by counsel. Between March 25, 1998 and October 14, 1998, Nord and MetLife exchanged letters and medical documentation in an effort to process the review of his claim.

This review process included the Plan's referral of Nord to Dr. Antoine Mitri for independent evaluation of his medical claims. Dr. Mitri observed Nord to be normal except for some limitations in bending and assuming cramped or unusual positions. Dr. Mitri opined that Nord should be able to perform sedentary work, with no material limitations in his ability to sit, while taking pain reduction medication. However, the review process also included Nord's providing the Plan with a work capacity evaluation performed by Ms. Janmarie Forward, a human resources representative at Black & Decker, who determined that Nord lacked the capacity to perform the requirements of his job because of his physical limitations. Forward based this determination on the assumption that Nord faced chronic myofascial pain and that this experience of pain would make it impossible for him to carry on the necessary interpersonal relationships to perform his job.

MetLife made a final recommendation to the Plan Manager to deny Nord's claim, and the Plan Manager accepted that recommendation. In a letter dated October 27, 1998, the Plan Manager informed Nord by letter of the

outcome of this initial step in his appeal and explained how Nord could perfect his appeal under ERISA. Black & Decker indicated that it had rejected the opinion of Forward that Nord's pain syndrome prevented him from resuming work in his former position.

Nord filed this action in the district court on January 14, 1999, asserting that Black & Decker's denial of his disability benefits violated ERISA. On February 28, 2000, the parties filed cross-motions for summary judgment. The district court granted the defendant's motion and denied Nord's motion. The court found that Black & Decker did not abuse its discretion by denying Nord's disability claim. Nord appeals the district court's order.

## STANDARD OF REVIEW

We review the district court's order granting summary judgment *de novo*. *See Robi v. Reed,* 173 F.3d 736, 739 (9th Cir. 1999). In addition, we review *de novo* "the district court's choice and application of the standard of review applicable to decisions of plan administrators in the ERISA context." *Regula v. Delta Family-Care Disability Survivorship Plan,* 266 F.3d 1130, 1138 (9th Cir. 2001); *see also Lang v. Long-Term Disability Plan of Sponsor Applied Remote Tech., Inc.,* 125 F.3d 794, 797 (9th Cir. 1997).

In reviewing a grant of summary judgment, we "must determine whether the evidence, viewed in a light most favorable to the nonmoving party, presents any genuine issues of material fact and whether the district court correctly applied the law." *Warren v. City of Carlsbad,* 58 F.3d 439, 441 (9th Cir. 1995); Fed. R. Civ. P. 56(c). *See also Pomerantz v. County of Los Angeles,* 674 F.2d 1288, 1290 (9th Cir. 1982) (holding that the same standard applies for



review of denial of summary judgment). An issue is genuine "if the evidence is such that a reasonable jury could return a verdict for the nonmoving party." *Anderson v. Liberty Lobby, Inc.,* 477 U.S. 242, 248 (1986).

## DISCUSSION

*District Court's standard of review for Black & Decker's disability determination*

The district court reviewed Black & Decker's termination of Nord's disability benefits under an abuse of discretion standard, despite Nord's allegations that Black & Decker was operating under a conflict of interest. Nord relies on the opinion of Black & Decker's own human resources representative and the opinions of three treating physicians that Nord was no longer capable of occupying his former position. He argues that Black & Decker's arbitrary rejection of these opinions constitutes material, probative evidence that it was operating under an actual conflict. Nord further argues that, because Black & Decker was operating under a conflict of interest, the district court should have reviewed the administrator's decision *de novo*.

The standard of judicial review for a disability determination by an insurer covered under ERISA varies depending on the plan language. We review *de novo* the decision of a plan administrator to deny benefits "unless the benefit plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan." *Firestone Tire & Rubber Co. v. Bruch,* 489 U.S. 101, 115 (1989); *see also Tremain v. Bell Indus., Inc.,* 196 F.3d 970, 976 (9th Cir. 1999). The plan language must be explicit. *See Kearney v.*

*Standard Ins. Co.*, 175 F.3d 1084, 1090 (9th Cir. 1999) (en banc) (holding that plan language stating that the insurer will pay benefits "upon receipt of satisfactory written proof" of disability was ambiguous, and thus did not confer discretion). When the plan language confers discretion, we review the decision of the plan administrator under an abuse of discretion standard. *Tremain*, 196 F.3d at 976.

In this case, the plan language clearly confers discretion upon the Plan Manager both to determine benefits eligibility and to interpret the terms of the Plan.[5] However, the fact that the terms of the Plan confer broad discretionary authority upon the plan administrator does not end our inquiry into the proper standard of review. An insurer with a "dual role as the administrator and funding source for the [p]lan" has an inherent conflict of interest. *Lang*, 125 F.3d at 797. In *Firestone Tire & Rubber Co.*, the Supreme Court stated that "if a benefit plan gives discretion to an administrator or fiduciary who is operating under a conflict of interest, that conflict must be weighed as a facto[r] in determining whether there is an abuse of discretion." 489 U.S. at 115 (internal quotation marks omitted). We have held that our review in such cases is "still for abuse of discretion, [but it] is less deferential." *Tremain*, 196 F.3d at 976 (internal quotation marks omitted).

Black & Decker admits that it acts as both the funding source and the plan administrator with regard to the Plan. It notes that administration of the Plan in Nord's

[5] *See supra* note 1.



case had been delegated to MetLife, a third-party administrator. However, MetLife acted as the agent of Black & Decker and not as the independent executor of a true trust.[6] *See Lang*, 125 F.3d at 798 (stating that "plans such as this one, funded by insurers and also administered by them, are not true trusts"). Therefore, Black & Decker, through MetLife, was operating under an inherent conflict of interest.

The "less deferential" standard of review for cases involving conflicts consists of two steps:

> First, we must determine whether the affected beneficiary has provided material, probative evidence, beyond the mere fact of the apparent conflict, tending to show that the fiduciary's self-interest caused a breach of the administrator's fiduciary obligations to the beneficiary. If not, we apply our traditional abuse of discretion review. On the other hand, if the beneficiary *has* made the required showing, the principles of trust law require us to act very skeptically in deferring to the discretion of an administrator who appears to have committed a breach of fiduciary duty.

*Atwood v. Newmont Gold Co., Inc.*, 45 F.3d 1317, 1323 (9th Cir. 1995). By providing material, probative evidence of a conflict, Nord would create a rebuttable presumption that the Plan's decision violated its fiduciary responsibilities. The Plan would then "bear[ ] the burden of rebutting the

[6] MetLife processes the insured's claim and makes a recommendation whether to grant or deny benefits; Black & Decker's Plan Manager makes the final disability determination after receiving MetLife's recommendation.

presumption by producing evidence to show that the conflict of interest did not affect its decision to deny or terminate benefits." *Lang,* 125 F.3d at 798. If the plan fails to carry its burden, then we review *de novo* its decision to deny benefits. *Tremain,* 196 F.3d at 976.

This appeal is controlled by our recent ruling in *Regula v. Delta Family-Care Disability Survivorship Plan.* In *Regula,* we rejected the district court's application of the abuse of discretion standard to a claim for wrongful termination of disability benefits because the district court had failed to evaluate whether the insurer's apparent conflict of interest had affected its determination. If so, we would require that the court review the plan administrator's decision *de novo. Regula,* 266 F.3d at 1145-46; *see also Lang,* 125 F.3d at 799-800 ("The district court did not conduct the appropriate conflict of interest analysis and hence accorded [the insurer] a deference to which it was not entitled."). Our prior decisions have established that material, probative evidence of a conflict may consist of inconsistencies in the plan administrator's reasons, *Lang,* 125 F.3d at 799, insufficiency of those reasons, *Tremain,* 196 F.3d at 977, or procedural irregularities in the processing of the beneficiaries claims, *Friedrich v. Intel Corp.,* 181 F.3d 1105, 1110 (9th Cir. 1999). In *Regula,* we held that rejection of the opinions of the beneficiary's treating physicians could likewise establish conflict where the rejection is not "sufficiently supported by the record." 266 F.3d at 1147. On remand, we directed the district court to consider Delta's departure from the prevailing opinions of Regula's treating physicians as material, probative evidence of an actual conflict of interest but to allow Delta to rebut that evidence in a manner consistent with our prior



precedent. *See Lang,* 125 F.3d at 798; *see also Tremain,* 196 F.3d at 978.

In *Regula,* the conflict of interest issue was not litigated in the district court but was entertained by us on appeal because of its relevance to determining the standard of review. 266 F.3d at 1145-46. Therefore, we did not rule on the existence of a conflict of interest in that case. *Id.* at 1147. Rather, we remanded to the district court so that the defendant insurer would have an opportunity to rebut the material, probative evidence of conflict that we ascertained in our review of the district court record. *Id.*

In the case before us, the district court rejected Nord's argument that inconsistencies and procedural irregularities in Black & Decker's administration of his claim demonstrated the insurer's conflict of interest. In particular, the district court held that Black & Decker's rejection of the conclusion of its own human resources representative, Forward, was not material, probative evidence of a conflict. Forward opined that Nord was unable, due to his medical condition, to perform the functions of a Material Planner. Forward's opinion was solicited by the administrator; she relied on Dr. Mitri's assessment as provided by the administrator. To contradict her opinion out of hand is not only high-handed but also certainly some evidence of a conflict.[7]

---

[7] In addition, Nord claims that the Plan violated its administrative procedural requirements by failing to provide, in its letter of October 27, 1998, specific reasons for rejecting the opinion of Forward. However, Black & Decker's letter was sufficiently responsive in that it provided the insurer's reasons for its ultimate decision to deny benefits. Black & Decker was under no duty to rebut with specificity all evidence adduced

(Continued on following page)

The district court erred also in its refusal to view Black & Decker's rejection of the prevailing opinions of Nord's treating physicians as germane to a determination of whether the Plan's administration was impaired by a conflict of interest. As discussed above, Nord was diagnosed with degenerative disc disease, sciatica, and myofascial pain syndrome. This diagnosis was confirmed by an MRI and CT scan and was not contradicted by Dr. Mitri, the independent clinician retained by Black & Decker to evaluate Nord's claim. Nord's primary treating physician, Dr. Hartman, concluded after a physical capacity evaluation that Nord could sit for up to one hour a day and could carry up to five pounds.[8] Black & Decker's own description of the physical requirements for a Material Planner indicate that the person occupying the position would have to sit for up to six hours a day and carry up to 20 pounds.[9] In addition, Dr. Hartman wrote two letters to Black & Decker in which he stated that Nord's medical condition prevented him from returning to work even though Nord had made improvements with physical therapy and

---

by Nord to support his claim. *Vizcaino v. Microsoft Corp.*, 120 F.3d 1006, 1016 (9th Cir. 1997) (en banc) (Fletcher, B., J., concurring in part and dissenting in part) (stating that under ERISA the reasons for a denial of benefits "must be stated in reasonably clear language, with specific reference to the plan provisions that form the basis for the denial") (quoting *Booton v. Lockheed Med. Benefit Plan*, 110 F.3d 1461, 1463 (9th Cir. 1997)).

[8] This diagnosis of Nord's physical abilities was confirmed by an additional examination by Dr. Williams, who opined that Nord could sit for one hour at a time and for one hour during a day, and that he could occasionally lift up to five pounds.

[9] Nord represents that while working in his former position he was sometimes required to lift up to 60 pounds.



medication. Dr. Hartman's diagnosis, as well as his prescribed course of treatment, were confirmed by Nord's other treating physicians, Drs. Williams and Silva.

Dr. Mitri disagreed with Nord's treating physicians in two principal respects: First, Dr. Mitri found that Nord suffered from only minor limitations to his range of motion and in his ability to sit for long periods of time if he took his pain medication. The medications to which Dr. Mitri referred in drawing this conclusion (Relafen, Davrocet, and Flexeril) are all medications that were prescribed by Drs. Hartman and Silva for Nord at various stages throughout their treatment of his condition. Second, Dr. Mitri concluded that Nord could lift and carry up to 15 pounds less than 20% of the business day. Thus, Dr. Mitri concluded that, under medication, Nord could perform "sedentary work with some walking interruption in between."

Thus, the long-term treating physicians and Black & Decker's independent (but one-time) clinical examiner disagreed. The same clinical materials were available to both. In such a circumstance, under the treating physician rule, the plan administrator can reject the conclusions of the treating physicians only if the administrator "gives 'specific, legitimate reasons for doing so that are based on substantial evidence in the record.'" *Morgan v. Comm'r of Soc. Sec. Admin.*, 169 F.3d 595, 600 (9th Cir. 1999) (quoting *Andrews v. Shalala*, 53 F.3d 1035, 1041 (9th Cir. 1995)).

Nowhere in the record is any reason advanced as to why the treating physicians' opinions were unreliable and Dr. Mitri's more reliable. No evidence has been advanced that Nord's treating physicians considered inappropriate

factors in making their diagnosis or that Nord's physicians lacked the requisite expertise to draw their medical conclusions. Instead, the administrator appears merely to have preferred to rely upon the more favorable conclusions of its own examiner. Given its dual role as funding source and administrator for the Plan, we conclude Black & Decker breached its fiduciary duty to Nord as a beneficiary of the Plan due to a conflict of interest.

Because the issue of an apparent conflict of interest was litigated below, Black & Decker received ample opportunity to demonstrate that its termination of Nord's benefits was free from conflict by advancing sound reasons for its denial of benefits. It has provided none. Rather, it has simply asserted at every turn, and again before this Court, that it was under no duty to consider evidence that was unfavorable to its determination, whether coming from Nord's physicians or from its own human resources representative. We faced an analogous situation in *Tremain,* where we ruled that the district court had erred by failing to consider evidence even though it was outside of the administrative record in determining whether a conflict of interest had impaired the insurer's benefits determination. 196 F.3d at 976-77. Based on the evidence before us, presented to the district court before it granted the insurer's motion for summary judgment, we concluded that the insurer's inconsistent reasons for denying the beneficiary's claim constituted material, probative evidence of a conflict (a conclusion not reached by the district court) and that the insurer had failed to present any evidence to rebut the presumption that a conflict of interest had impaired its determination. *Id.* at 977.

Therefore, following our precedent in *Tremain* and *Regula,* we conclude that the disability determination



must be reviewed *de novo.* Under *de novo* review, the question becomes whether there is a genuine issue of material fact as to whether Nord is disabled. *See Newcomb v. Standard Ins. Co.,* 187 F.3d 1004, 1006 (9th Cir. 1999). After cross-motions for summary judgment, we find that, although further record development for *de novo* review is sometimes appropriate, *see Mongeluzo v. Baxter Travenol Long Term Disability Benefit Plan,* 46 F.3d 938, 943-44 (9th Cir. 1995), it is unnecessary in this case. Indeed, Black & Decker asserted in the district court that no additional evidence was necessary for an adequate *de novo* review. *See* Defendant's Memorandum of Points and Authorities in Opposition to Plaintiff's Motion for Summary Judgment at 17 & n.6. The administrative record reveals no genuine dispute as to whether Nord is disabled within the meaning of the plan for the first 30 months of coverage.

The only evidence advanced by Black & Decker to dispute the evidence of Nord's disability is Dr. Mitri's opinion that Nord is capable of performing sedentary work. A scintilla of evidence or evidence that is not significantly probative does not present a genuine issue of material fact. *Addisu v. Fred Meyer, Inc.,* 198 F.3d 1130, 1134 (9th Cir. 2000). We conclude that the lone opinion of Dr. Mitri, the doctor hired by Black & Decker, could not reasonably overcome all the other evidence demonstrating that Nord is disabled. Dr. Mitri's opinion is overwhelmed by substantial evidence in the record, including the opinions of three treating physicians that Nord's condition rendered him unable to meet the physical requirements of his position as a Material Planner. Viewing the administrative record as a whole, we conclude that no reasonable

trier of fact could conclude that Nord is not disabled. Therefore, we grant Nord's motion for summary judgment.

## CONCLUSION

For the foregoing reasons, we reverse the ruling of the district court holding that Black & Decker was not operating under a conflict of interest. Upon a *de novo* review of the administrative record, we find that there is no triable issue of fact regarding Nord's disability and hold that Nord is entitled to disability benefits for the first 30 months of his disability.

REVERSED.

---



JUDGMENT

---

UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

---

NO. 00-55689
CT/AG#: CV-99-00408-CM
CT/AG#: CV-99-00408-CM

KENNETH L. NORD

Plaintiff-Appellant

v.

THE BLACK & DECKER DISABILITY PLAN

Defendant-Appellee

---

APPEAL FROM the United States District Court for the Central District of California, Los Angeles.

THIS CAUSE came on to be heard on the Transcript of the Record from the United States District Court for the Central District of California, Los Angeles and was duly submitted.

ON CONSIDERATION WHEREOF, It is now here ordered and adjudged by this Court, that the judgment of the said District Court in this cause be, and hereby is reversed.

Filed and entered: July 15, 2002

---

UNITED STATES DISTRICT COURT
CENTRAL DISTRICT OF CALIFORNIA

KENNETH L. NORD,
Plaintiff,
v.
THE BLACK & DECKER DISABILITY PLAN,
Defendant.

Case No. CV 99-0408 CM

ORDER GRANTING DEFENDANT'S MOTION FOR SUMMARY JUDGMENT AND DENYING PLAINTIFF'S MOTION FOR SUMMARY JUDGMENT

(Filed Mar. 22, 2000)

On February 28, 2000, Plaintiff's Motion for Summary Judgment and Defendant's Motion for Summary Judgment came before the Court on regular hearing. Having read and considered the moving papers, oppositions, and replies; the entire record in this action; and all other admissible evidence and argument offered in relation to the Motions, the Court hereby *grants* Defendant's Motion for Summary Judgment and hereby *denies* Plaintiff's Motion for Summary Judgment for the following reasons.

I.

Summary of Relevant Facts

This ERISA action arises from Plaintiff's claim for long-term disability benefits from Defendant. Plaintiff is a former employee of Kwikset Corporation ("Kwikset"), a subsidiary of Black & Decker Corporation. As a Kwikset employee, Plaintiff was entitled to participate in the Black & Decker Disability Plan (the "Plan"). Under the terms of the Plan, "disability" was defined as follows:



> the complete inability (whether physical and/or mental) of a Participant to engage in his regular occupation with the Employer (during the first 30 months of Disability and beginning with the thirty-first month of Disability, the Participants [sic] complete inability (whether physical and/or mental) of a participant to engage in any gainful occupation or employment with an employer for which the Employee is, as of his Disability Date, reasonably qualified by education, experience or training. Declaration of Raymond J. Brusca In Support of Defendant's Motion, Exh. B at 24.

On or about July 15, 1997, Plaintiff ceased working in his position as a Material Planner for Kwikset and submitted his claim for long-term disability benefits. A review of Plaintiff's administrative claim file reveals the following facts relevant to the disposition of the instant Motions:

– On or about March 10, 1997, Plaintiff consulted with Leo Hartman, M.D. because of the presence of intermittent pain in the lower back and hips for the preceding three or four weeks;

– Between March 1997 and August 1997, Plaintiff was regularly treated by Dr. Hartman for lower back pain, sciatica, leg pain, and degenerative disc disease. As part of his treatment by Dr. Hartman, pain killers were prescribed for Plaintiff;

– On or about August 13, 1997, Dr. Hartman recommended that Plaintiff seek an orthopedic consultation from Ismael Silva, M.D.;

– Also on or about August 13, 1997, Dr. Hartman wrote a letter in which he indicated that Plaintiff was

under his medical care and could not return to work until Plaintiff's lumbar disc syndrome had sufficiently recovered;

– As result of Plaintiff's consultation with Dr. Silva, Dr. Silva diagnosed Plaintiff with lumbosacral pain and prescribed physical therapy;

– On or about the same time as Dr. Silva's prescription of physical therapy for Plaintiff, Dr. Hartman also prescribed physical therapy for Plaintiff;

– Dr. Silva's treatment of Plaintiff included prescription painkillers as well as ordering an EMG and nerve conduction studies of Plaintiff's lower extremities in order to rule out disc disease;

– The results of the EMG and nerve conduction studies ordered by Dr. Silva suggested mild bilateral L5 radiculopathy;

– On or about January 12, 1998, Kwikset provided a statement regarding Plaintiff's claim for long-term disability benefits to Metropolitan Life Insurance Company ("MetLife"), the Plan's Third Party Claims Administrator. In that statement, Kwikset described Plaintiff's position as a Material Planner as requiring between five and six hours of sitting per day, one and two hours of standing, one and two hours of walking, the need to use the head and neck in the same position between one and two hours per day, looking up between one and two hours per day, and looking down between one and two hours a day. Kwikset further represented that the Material Planner position required occasional lifting and carrying of objects weighing up to 20 pounds, continuous interpersonal relationships, frequent exposure to stressful situations,



exposure to moving equipment and machinery, and overtime on a routine basis;

– On or about January 17, 1998, Plaintiff provided a response to a Personal Profile Evaluation as part of Metlife's assessment of his claim for long-term disability benefits. In the Personal Profile Evaluation, Plaintiff reported that he could not sit for more than 10 to 15 minutes at a time without pain, that he could not stand or walk for more than 10 to 15 minutes without pain, that pain radiated down his left leg and at times also down his right leg, that he walked until he experienced pain and then sat in a recliner and stood at invervals during a typical day, that he had no difficulty caring for his personal needs, that he did housework and that he got assistance from his mother with housework, that his father provided him assistance with shopping, that it takes him longer to mow his lawn because of his pain, and that his recreational activities included fishing and hunting although he had not been hunting since November of 1996. Plaintiff further stated that he expected to return to his job as a Material Planner if and when he could sit without pain; that, in the meantime, he did not expect to return to any other type of work on a full-time or part-time basis; and that he had no other sources of income;

– On or about January 23, 1998, Plaintiff returned to Dr. Silva for evaluation. Dr. Silva noted continued complaints of back pain, bilateral lumbosacral radiculopathy, and the continued use of prescription medication to control pain. Dr. Silva also found decreased lumboscaral range of motion and the presence of paralumbar muscle spasm;

– On or about February 16, 1998, MetLife wrote a letter to Plaintiff regarding his claim. In the letter, MetLife

disallowed Plaintiff's claim for benefits. In so doing, MetLife cited Plaintiff's responses in his Personal Profile Evaluation as well as Plaintiff's medical history since the onset of his lower back pain. MetLife's letter also notified Plaintiff of his right to seek review of its denial of Plaintiff's claim by the Plan's Group Claims Review;

– On or about March 4, 1998, Plaintiff returned to Dr. Hartman with continuing complaints of lower back pain. Dr. Hartman noted the presence of recurring low back pain consistent with a herniated disc. Dr. Hartman recommended continuing the present treatment regiment and seeking an orthopedic follow-up from Lytton Williams, M.D.;

– On or about March 23, 1998, Dr. Hartman wrote a letter concerning Plaintiff. In the letter, Dr. Hartman confirmed Plaintiff's continuing treatment for lumbar disc syndrome. Dr. Hartman also stated that Plaintiff would not be able to work until his condition was sufficiently controlled and that Plaintiff would likely be of work until December 31, 1998;

– On or about March 25, 1998, Plaintiff, through his counsel, formally requested review of the denial of his claim;

– On or about March 26, 1998, Plaintiff underwent a lumbar discogram and a CT scan of the lumbar spine both based upon a clinical history of degenerative disc disease. The discogram revealed a concordant pain pattern at L4-5 and L5-S1. The CT scan revealed annular thinning of the intervertebral discs and loss of disc space at L4-5 and L5-S1;



– On or about April 2, 1998, Dr. Williams completed a Physical Capacity Evaluation Plaintiff. Dr. Williams opined that Plaintiff could sit for one hour at a time and for one hour total during a day; that Plaintiff could occasionally lift or carry up to five pounds; that Plaintiff could not use his feet for repetitive movements; that Plaintiff could only occasionally bend, squat, crawl, climb, or reach; and that Plaintiff should be limited to mild exposure to temperature and humidity changes;

– On or about April 9, 1998, Dr. Hartman completed a Physical Capacity Evaluation of Plaintiff. Dr. Hartman opined that Plaintiff could sit for one hour at a time and for a total of one hour per day; that Plaintiff could occasionally lift up to five pounds; that Plaintiff could not use his feet for pushing or pulling of light controls; that Plaintiff could occasionally bend, squat, crawl, climb, or reach; and that Plaintiff should be limited to mild exposure to temperature and humidity changes;

– On or about June 22, 1998, MetLife advised Plaintiff that it had scheduled an independent medical examination of Plaintiff as part of its administration of Plaintiff's claim;

– On or about July 17, 1998, Antoine Mitri, M.D. conducted an independent neurological examination of Plaintiff pursuant to MetLife's request. Dr. Mitri concluded that Plaintiff suffered from degenerative disc disease and chronic myofascial pain syndrome. Dr. Mitri further concluded that there was no evidence of lumbosacral nerve root compression. Consequently, Dr. Mitri opined that Plaintiff should be able to do sedentary work with intermittent walking as necessary;

– On or about July 17, 1998, Dr. Mitri completed a Certified Consultant's Evaluation Summary Form as part

of MetLife's administration of Plaintiff's claim. In that form Dr. Mitri noted the presence of lumbosacral degenerative disc disease and chronic myofascial pain syndrome and that Plaintiff had suffered from low back pain for 15 years. Dr. Mitri opined that Plaintiff would have some limitations with respect to stairs and ladders and that Plaintiff would need to completely avoid scaffolding and heights. Dr. Mitri further found limitations with respect to cramped or unusual positions, pushing, pulling, or twisting of arm and leg controls, repetitive movements of hands or feet, and operating vehicles. Dr. Mitri completely forbade climbing, balancing, bending, stooping, squatting, and the operation of heavy equipment. Dr. Mitri opined that Plaintiff could perform sedentary work with occasional walking;

– At some point prior to October 20, 1998, Janmarie Forward, a Black & Decker human resources employee, completed a Work Capacity Evaluation sent to her by Plaintiff's counsel;

– On or about October 27, 1998, Black & Decker upheld MetLife's denial of Plaintiff's claim. Black & Decker based its decision on its conclusion that Plaintiff could return to work in his own occupation which was, in turn, based on the evidence in Plaintiff's administrative claim file;

– Subsequent to its decision to uphold the denial of Plaintiff's claim, Black & Decker requested a review of the medical records and correspondence relating to Plaintiff's claim by James Ebeling, M.D. Dr. Ebeling concluded that Plaintiff should be able to do sedentary work and he agreed with MetLife's decision to deny Plaintiff's claim.



## II.

## Applicable Standard

Summary judgment is appropriate when "the pleadings, depositions, answers to interrogatories, and admissions on file, together with the affidavits, if any, show that there is no genuine issue as to any material fact and that the moving party is entitled to judgment as a matter of law." Fed. R. Civ. P. 56(c). In a trilogy of 1986 cases, the Supreme Court clarified the applicable standards for summary judgment. *See Celotex Corporation v. Catrett*, 477 U.S. 317 (1986); *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242 (1986); *Matsushita Electrical Industry Co. v. Zenith Radio Corp.*, 475 U.S. 574 (1986).

The moving party bears the initial burden of demonstrating the absence of a genuine issue of material fact. *Anderson*, 477 U.S. at 256. Whether a fact is material is determined by looking to the governing substantive law; if the fact may affect the outcome, it is material. *Id.* at 248. If the moving party seeks summary adjudication with respect to a claim or defense upon which it bears the burden of proof at trial, its burden must be satisfied by affirmative, admissible evidence. By contrast, when the non-moving party bears the burden of proving the claim or defense, the moving party can meet its burden by pointing out the absence of evidence submitted by the non-moving party. The moving party need not disprove the other party's case. *See Celotex*, 477 U.S. at 325.

If the moving party meets its initial burden, the "adverse party may not rest upon the mere allegations or denials of the adverse party's pleadings, but the adverse party's response, by affidavits or as otherwise provided in

this rule, must set forth specific facts showing that there is a genuine issue for trial." Fed. R. Civ. P. 56(e).

In assessing whether the non-moving party has raised a genuine issue, its evidence is to be believed, and all justifiable inferences are to be drawn in its favor. *Anderson*, 477 U.S. at 255 (citing *Adickes v. S. H. Kress and Company*, 398 U.S. 144 (1970)). Nonetheless, "the mere existence of a scintilla of evidence" is insufficient to create a genuine issue of material fact. *Id.* at 252. As the Supreme Court explained in *Matshushita*,

> When the moving party has carried its burden under Rule 56(c), its opponent must do more than simply show that there is some metaphysical doubt as to the material facts. . . . Where the record taken as a whole could not lead a rational trier of fact to find for the nonmoving party, there is no "genuine issue for trial."

*Id.*, 475 U.S. at 586-87.

To be admissible for purposes of summary judgment, declarations or affidavits must be based on personal knowledge, must set forth "such facts as would be admissible in evidence," and must show that the declarant or affiant is competent to testify concerning the facts at issue. Fed. R. Civ. P. 56(e). Declarations on information and belief are insufficient to establish a factual dispute for purposes of summary judgment. *Taylor v. List*, 880 F.2d 1040, 1045 (9th Cir. 1989).

Summary judgment is not treated as "a disfavored procedural shortcut" but as "an integral part of the Federal Rules as a whole, which are designed 'to secure the just, speedy and inexpensive determination of every action.'" *Celotex*, 477 U.S. at 327 (quoting Fed. R. Civ. P. 1).



III.

Analysis and Discussion

*Exhaustion of Administrative Remedies*

As a general rule, "[an ERISA] claimant must avail himself or herself of a plan's own internal review procedures before bringing suit in federal court." *Diaz v. United Agricultural Employee Welfare Benefit Plan and Trust*, 50 F.3d 1478, 1483 (9th Cir. 1995) (citing *Amato v. Bernard*, 618 F.2d 559, 566-68 (9th Cir. 1980)), *see also Pengilly v. Guardian Life Insurance Co. of America*, 81 F.Supp.2d 1010, 1022 (N.D.Cal. 2000) (setting forth the specific terms of a disability policy's appeal's procedures in order to analyze the issue of exhaustion of administrative remedies). "Although not explicitly set out in the statute, the exhaustion doctrine is consistent with ERISA's background, structure and legislative history and serves several important policy considerations, including the reduction of frivolous litigation, the promotion of consistent treatment of claims, the provisions of a nonadversarial method of claims settlement and a proper reliance on administrative expertise." *Diaz*, 50 F.3d at 1483. "Furthermore, prior fully considered actions by . . . trustees interpreting their plans and perhaps also further refining and defining the problem in given cases, may well assist the courts when they are called upon to resolve the controversies." *Pengilly*, 81 F.Supp.2d at 1022 (citing *Amato v. Bernard*, 618 F.2d at 568).

The Summary Plan Description ("SPD"), *see* Brusca Decl. Exh. A, clearly provides that a claimant may appeal to the Plan Administrator within 60 days of the initial denial of a claim and that the Plan Administrator will render its decision on the appeal within another 60 days.

Furthermore, the Plan Document itself, *see* Brusca Decl., Exh. B, provides that initial determinations of claims applications will be made by the Plan Manager or by a third party Claims Administrator who is providing administrative services to the Plan. *See* Brusca Decl., Exh. A, §9.07(A). Under the terms of the Plan Document, a claimant may appeal an initial denial of benefits to the Plan Manager within 60 days of the initial denial. *See id.* at §9.07(B). Finally, the Plan Document provides that the appeal will be decided by an Appeals Committee within 60 days of the date the claimant makes the appeal. *See id.* at §9.07(C).

Plaintiff argues that he exhausted his administrative remedies under the Plan Document and the SPD when he received a letter dated October 27, 1998 from Black and Decker, *see* Brusca Decl., Exh. D, notwithstanding the fact that this letter purported to inform Plaintiff of his right under ERISA to have claim reviewed on appeal yet again. Specifically, Plaintiff claims that the October 27, 1998 letter was notification of a final, binding decision on his appeal of MetLife's initial denial of his claim in its position as Third Party Administrator.

Defendant, however, characterizes MetLife's initial denial as a kind of recommendation to the Plan Manager which the Plan Manager upheld after further investigation. *See* Brusca Decl. ¶¶11-19. Therefore, according to Defendant, under the terms of the Plan and the SPD, Plaintiff was still entitled to an appeal to the Plan's Appeals Committee. *See id.* ¶¶20-22. Because, according to Defendant's position, Plaintiff did not pursue an appeal to the Plan's Appeals Committee, this action is barred for failure to exhaust administrative remedies. *See* Defendant's Motion at 3-6, Defendant's Opposition at 4-5.



The Court holds that Plaintiff has exhausted his administrative remedies by making his initial claim and seeking review by the Plan Manager which resulted in the denial in the October 27, 1998 letter. There is no ambiguity in the SPD about the internal appeals process and to the extent there is any ambiguity in the Plan Document itself, *see* Brusca Decl. Exh. B at §§9.07(A)-(B), Plaintiff should not be prejudiced thereby. The SPD clearly provides that Plaintiff is entitled to one level of internal appeal after the initial denial; the Plan Document has similar terms. Nothing in these documents puts a claimant on notice of the fact that an initial denial by the Third Party Claims Administrator might be a mere recommendation that must be ratified by the Plan Manager before an actual internal appeal can take place. Furthermore, the initial denial letter sent to Plaintiff by MetLife, *see* Brusca Decl. Exh. C at 147, also states that Plaintiff had 60 days to request a review of MetLife's initial denial. This language may have reasonably led Plaintiff and his counsel to conclude that the October 27, 1998 denial was the product of the only level of internal appeal to which Plaintiff was entitled under the SPD and the Plan Document. Consequently, the Court concludes that Plaintiff exhausted his administrative remedies and that, therefore, this action is not barred.[1]

---

[1] Tellingly, the draft version of Black & Decker's October 28, 1998 denial letter which was written by MetLife stated that the decision to uphold MetLife's denial "is the final decision on review and constitutes completion of the full and fair review required by Mr. Nord's Plan and federal law." The draft denial letter further states "Please be advised that under the provisions of his Plan, no further administrative appeals are available to him concerning his disability benefit." Rohlfing Decl.,

(Continued on following page)

*Appropriate Standard of Review / Conflict of Interest*

An ERISA plan administrator's decision to deny benefits is subject to de novo review unless the benefit plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan. *Tremain v. Bell Industries*, 196 F.3d 970, 976 (9th Cir. 1999) (citing *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 115 (1989)). When such discretion is conferred, the exercise of that discretion is subject to review for abuse of discretion. *Tremain*, 196 F.3d at 976 (citing other Ninth Circuit caselaw).

"If, however, the plan administrator is also the insurer, that conflict of interest must be weighed as a factor in determining whether there is an abuse of discretion." *Id.* (citing *Snow v. Standard Insurance Co.*, 87 F.3d 327, 330 (9th Cir 1996)). In such a circumstance, a "less deferential" abuse of discretion standard is employed. *Tremain*, 196 F.3d at 976 (citing *Lang v. Long-Term Disability Plan of Sponsor Applied Remote Technology*, Inc. 125 F.3d 794, 798 (9th Cir. 1997)).

"If, however, the program participant presents material, probative evidence, beyond the mere fact of the apparent conflict, tending to show that the fiduciary's self-interest caused a breech of the administrator's fiduciary obligations to the beneficiary, a rebuttable presumption arises in favor of the participant." *Tremain*, 196 F.3d at

---

Exh. 2 at Bates No. BD 0039. Although the final version tracks MetLife's draft in many respects, the final version does not contain the above-quoted language. See Brusca Decl., Exh. D at 159 (Bates No. BD 0042).



976 (citing *Lang*, 125 F.3d at 798). "The plan then bears the burden of rebutting the presumption by producing evidence to show that the conflict of interest did not affect its decision to deny or terminate benefits. *Tremain*, 196 F.3d at 976 (citing *Lang*). If the plan fails to carry this burden of rebutting the presumption, the fiduciary or administrator's decision to deny benefits is reviewed de novo. *Tremain*, 196 F.3d at 976 (citing *Lang*). Sufficient evidence of an actual conflict of interest includes, *inter alia*: (1) inconsistent position on the part of the administrator/fiduciary or (2) an administrator/fiduciary's failure to follow its own internal procedures or ERISA's mandatory claims procedures. *See Ellis v. Egghead Software Short-Term and Long-Term Disability Plans*, 64 F.Supp.2d 980, 985 (E.D.Wash. 1999) (citing *Lang*, 125 F.3d at 799, and *Friedrich v. Intel Corp.*, 181 F.3d 1105, 1109-12 (9th Cir. 1999)).

Plaintiff concedes that the Plan Document grants discretion to the Plan Administrator. *See* Plaintiff's Motion at 4. Defendant likewise concedes that there is an apparent or technical conflict of interest due to Black & Decker's dual role as insurer and administrator. *See* Defendant's Motion at 11. However, Plaintiff has not sufficiently met his burden to invoke de novo review. *See* Defendant's Opposition at 10-15. More specifically, under *Ellis*, Plaintiff has not demonstrated that Defendant assumed inconsistent positions during the pendency of the internal claims assessment and internal appeal. Furthermore, to the extent that Defendant may have deviated from the SPD's and Plan Document's stated procedures for an internal appeal, this issue has been resolved in Plaintiff's favor above as it relates to exhaustion of administrative remedies and Plaintiff also has not shown that this

deviation caused a breach of fiduciary duty owed to him. *See Tremain*, 196 F.3d at 976 (plaintiff must produce sufficient evidence to show that the conflict of interest caused a breach of a fiduciary duty owed to him), *cf. Dames*, 49 F.Supp.2d at 1201 (a plaintiff is not entitled to a substantive remedy for violation of ERISA's reporting and disclosure requirements unless she can show reliance or prejudice).

Consequently, the Court holds that notwithstanding Defendant's apparent or technical conflict of interest, Defendant's decision to deny Plaintiff's claim for disability benefits is subject to review for abuse of discretion.

*Propriety of Defendant's Denial of Plaintiff's Claim for Benefits*

"It is an abuse of discretion for an ERISA plan administrator to make a decision without any explanation, or in a way that conflicts with the plain language of the plan, or that is based on clearly erroneous findings of fact." *Atwood v. Newmont Gold*, 45 F.3d 1317, 1323-24 (9th Cir. 1995). "The mere fact that the plan administrator's decision is directly contrary to some evidence in the record does not show that the decision is clearly erroneous." *Snow v. Standard Insurance Co.*, 87 F.3d 327, 331 (9th Cir. 1996). "Rather, 'review under the clearly erroneous standard is significantly deferential, requiring a 'definite and firm conviction that a mistake has been committed.'" *Id.* (citing *Concrete Pipe & Prods., Inc. v. Construction Laborers Pension Trust*, 508 U.S. 602, 623 (1993)). "That standard certainly does not permit the overturning of a decision where there is substantial evidence to support the decision, that is, where there is 'relevant evidence [that] reasonable minds might accept as adequate to support a



conclusion even if it is possible to draw two inconsistent conclusions from the evidence.'" *Snow*, 87 F.3d at 331-32 (citing *Maynard v. City of San Jose*, 37 F.3d 1396, 1404 (9th Cir. 1994)). Finally, several courts have held that crediting the opinions of an independent medical examiner over the opinions of a claimant's treating physicians is not clearly erroneous or an abuse of discretion. *See, e.g., Voight v. Metropolitan Life Insurance Co.*, 28 F.Supp.2d 569, 578-81 (C.D.Cal. 1998) (Morrow, J.) (citing other cases), *Jordan v. Northrop Gruman Corp. Welfare Benefit Plan*, 63 F.Supp.2d 1145, 1161-64 (C.D. Cal. 1999) (Collins, J.) (citing other cases) (finding that the administrator's decision to deny benefits was justified by sufficient evidence despite the fact that it contradicted the opinions of plaintiff's treating physicians).

In his briefing, Plaintiff's two main arguments in support of overturning Defendant's decision to deny him disability benefits are that: (1) Defendant's decision is contrary to the opinions provided by Janmarie Forward, a Black & Decker employee, in a Work Capacity Evaluation and (2) Defendant's decision credits the medical opinions of an independent medical examiner over the opinions of his Plaintiff's treating physicians. *See* Plaintiff's Motion at 11-19.

In making these arguments, Plaintiff essentially argues that Defendant's decision was based on factual findings which were clearly erroneous. It is clear under *Snow*, however, that the fact that Defendant's decision contradicts some evidence in the administrative record is not sufficient to overturn Defendant's decision. Consequently, the fact that an individual like Ms. Forward who apparently lacks any expertise or credentials in medicine, disability evaluation, and vocational evaluation has

expressed an opinion contrary to Defendant's ultimate decision is not sufficient reason to overturn Defendant's decision given the other evidence in the administrative record.[2] Furthermore, it is also clear that Defendant need not credit the opinion of Plaintiff's treating physician over the opinions of an independent medical examiner. *See Voight v. Metropolitan Life Insurance Co.*, 28 F.Supp.2d 569, 578-81 (C.D.Cal. 1998) (Morrow, J.) (citing other cases), *Jordan v. Northrop Grumman Corp. Welfare Benefit Plan*, 63 F.Supp.2d 1145, 1161-64 (C.D.Cal. 1999) (Collins, J.) (citing other cases). This is especially the case when MetLife gave Plaintiff and Plaintiff's treating physicians an opportunity to comment on the independent medical examiner's opinions, *see* Brusca Decl. Exh. D. at

[2] Item 6 of the Work Capacity Evaluation reads as follows:

> Dr. Mitri describes Kenneth Nord as suffering from degenerative disc disease and a chronic myofascial pain syndrome. You have indicated in your employer statement provided to Metropolitan that the work of a material planner requires continuous interpersonal relationships and frequent exposure to stressful job situations. Assume that Kenneth Nord would have a moderate pain that would interfere with his ability to perform intense interpersonal communications or to act appropriately under stress occasionally (up to one-third) during the day. Could [an] individual of those limitations perform the work of a material planner?" Brusca Decl, Exh. C at 40.

Ms. Forward responded "no" to Item 6. *Id.* furthermore, in its October 27, 1998 denial letter, Black & Decker specifically referenced Ms. Forward's response in the Work Capacity Evaluation and stated "The results of that evaluation are not sufficient to reverse our decision." Brusca Dec, Exh. D. at 159. Furthermore, as Defendant persuasively argued at the hearing on the instant Motions, Ms. Forward's response to Item 6 of the Work Capacity Evaluation did not take account of the prescription painkillers Plaintiff had been taking virtually since the onset of his lower back pain in early 1997.



159, and Plaintiff apparently never took advantage of this opportunity. *Cf. Dames*, 49 F.Supp.2d at 1202 (fact that administrator did not consider untimely submitted medical opinions is not evidence of taint sufficient to invoke de novo review because of conflict of interest; decision not to consider untimely evidence was exactly the kind of exercise of discretionary authority which administrator was entitled to make).

Finally, at the hearing on the instant Motions, Plaintiff's counsel emphasized a conversation between the Plan Manager, Raymond Brusca, and Ms. Forward, the Black & Decker human resources employee who provided responses on a Work Capacity Evaluation sent to Black & Decker by Plaintiff. Although Defendant admits that a conversation took place, Defendant has not disclosed the exact details of the conversation. In his declaration, Mr. Brusca does state that he discussed the specific duties of the Material Planner position, the freedom of movement Plaintiff had in that position, and the availability of aid to Plaintiff in lifting in that position if aid were necessary. Brusca Decl. ¶17.

At the hearing, Plaintiff's counsel pointed to this conversation both as evidence sufficient to meet Plaintiff's burden of demonstrating an actual conflict of interest and as evidence of an abuse of discretion on Defendant's part. The Court disagrees. Given Ms. Forward lack of expertise or credentials, her responses in the Work Capacity Evaluation cannot be said to constitute material evidence as Plaintiff claims. Consequently, any conversation between Mr. Brusca and Ms. Forward whether disclosed or undisclosed also cannot constitute evidence sufficient to demonstrate an actual conflict of interest or an abuse of discretion.

In sum, because an administrator's decision is not based on clearly erroneous factual findings when it conflicts with some evidence in the administrative record and because Defendant need not credit the opinions of Plaintiff's treating physicians over those of an independent medical examiner, the Court holds that Defendant did not abuse its discretion in denying Plaintiff's claim for benefits. *See Snow*, 87 F.3d at 331-32, *Voight*, 28 F.Supp.2d at 578-81, *Jordan*, 63 F.Supp.2d at 1161-64, *see also* Defendant's Opposition at 16-23, Defendant's Reply at 6-11, Defendant's Motion at 7-17.

## IV.

## Conclusion

For the foregoing reasons, the Court finds that Defendant has met its burden on summary judgment of demonstrating that there is no genuine dispute of material fact and that it is entitled to judgment as a matter of law. Also for the foregoing reasons, the Court finds that Plaintiff has not met his burden on summary judgment of demonstrating that there is no genuine dispute of material fact and that he is entitled to judgment as a matter of law. Therefore, the Court hereby *grants* Defendant's Motion for Summary Judgment and hereby *denies* Plaintiff's Motion for Summary Judgment.

IT IS SO ORDERED.

DATED: March 22, 2000.

/s/ Carlos R. Moreno
Carlos R. Moreno
United States District Judge

---



29 U.S.C. § 1132(a)(1)(B) (2002)

§ 1132. Civil enforcement

(a) Persons empowered to bring a civil action. A civil action may be brought –

(1) by a participant or beneficiary –

(A) for the relief provided for in subsection (c) of this section, or

(B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan;

* * *

---

28 U.S.C. § 1254(1)

§ 1254. Courts of appeals; certiorari; certified questions

Cases in the courts of appeals may be reviewed by the Supreme Court by the following methods:

(1) By writ of certiorari granted upon the petition of any party to any civil or criminal case, before or after rendition of judgment or decree;

* * *

---

[LOGO]

**U.S. Department of Labor**

**Pension and Welfare**
**Benefits Administration**
***www.dol.gov/pwba***

---

**September 4, 2002**
Benefit Claims Procedure Regulation

On November 21, 2000, the Department of Labor published in the Federal Register a final regulation that sets new standards for processing benefit claims of participants and beneficiaries who are covered under employee benefit plans governed by the Employee Retirement Income Security Act of 1974.

The new claims procedure regulation will begin to apply to some plans for new claims filed on or after January 1, 2002. It will not begin to apply to group health plans until the first day of the first plan year beginning on or after July 1, 2002, but not later than January 1, 2003. See 66 FR 35886 (July 9, 2001).

The claims procedure regulation changes the minimum procedural requirements for the processing of benefit claims for all employee benefit plans covered under ERISA, although the changes are minimal for pension and welfare benefit plans other than those that provide group health and disability benefits. For group health and disability benefit claims, the regulation substantially changes the procedures for benefit determinations. Among other things, it creates new procedural standards for initial and appeal-level decisions, new time frames for decision making, and new disclosure rights for claimants.



Since publication, the department has received many questions on how to apply the provisions of the new regulation. This document answers many of the frequently asked questions about the application of the regulation to group health and disability benefit plans. To the extent that the provisions of the regulation discussed below apply to other types of plans, the guidance provided in this document applies to those plans also. The department is publishing this guidance to assist plans in bringing their benefit processing systems into timely compliance with the new requirements. The department anticipates providing additional guidance in the form of additional questions and answers, advisory opinions, or information letters as may be necessary to facilitate implementation of the requirements of the regulation. The views expressed in this publication represent the views of the Department of Labor.

**A-1: Does the regulation apply to benefit claims filed by enrollees in federal programs, such as Medicare and Medicaid, or to federal employees and their families covered under the Federal Employees Health Benefits Program (FEHBP)?**

No. The regulation establishes requirements only for employee benefit plans that are covered under ERISA. See ERISA sections 3(1) and 3(2). Such plans are typically benefit programs provided by private-sector employers for their employees (or by unions, acting either independently or jointly with employers, for their members). Government programs, whether federal, state, or local, that are not related to employment, such as Medicaid and Medicare, are not covered by these claims procedure rules; neither are government-sponsored benefit programs for governmental employees, such as the FEHBP or benefit plans

provided by state or local governments to their own employees. Such plans have their own specific rules for claims procedures, which may derive from other federal law (for federal programs) or from state or local law.

---

**A-2: Does the regulation apply to benefit claims filed by persons who are both enrollees in Medicare + Choice programs and participants in an ERISA plan?**

The regulation applies only to benefits provided under an ERISA plan that are outside the scope of what is regulated by the Medicare program. Benefits provided under ERISA plans vary from plan to plan based on plan design. When a benefit is provided under an ERISA plan pursuant to a separate group arrangement between the Medicare + Choice organization and the employer (or employee organization), even though the benefit is only available to enrollees in a Medicare + Choice program, we have been advised by HHS that the benefit would be outside the scope of what is regulated by the Medicare program. Claims for such benefits would be subject to the provisions of the regulation. The primary source of information about these ERISA benefits is the summary plan description for the plan, which is available on request from the plan administrator. On the other hand, benefits that are covered under a Medicare + Choice contract (whether they are Medicare benefits, additional benefits paid for by Medicare, or supplemental benefits paid for through a premium charged to all enrollees) are subject to the Medicare + Choice rules for organization determinations, appeals, and grievances under 42 CFR 422 and not the provisions of the regulation. See question A-1. A person who is covered by a



Medicare + Choice program and wants more information on how these Medicare + Choice rules apply to his or her coverage should call 1.800.Medicare. He or she may also want to consult their Medicare Regional Office and 1.800.Medicare can assist them in contacting the appropriate office.

---

**A-3: Does the regulation apply to a request for a determination whether an individual is eligible for coverage under a plan?**

The regulation applies to coverage determinations only if they are part of a claim for benefits. The regulation, at § 2560.503-1(e), defines a claim for benefits, in part, as a request for a plan benefit or benefits made by a claimant in accordance with a plan's reasonable procedure for filing benefit claims. A claim for group health benefits includes pre-service claims (§ 2560.503-1(m)(2)) and post-service claims (§ 2560.503-1(m)(3)). If an individual asks a question concerning eligibility for coverage under a plan without making a claim for benefits, the eligibility determination is not governed by the claims procedure rules. If, on the other hand, the individual files a claim for benefits in accordance with the plan's reasonable procedures, and that claim is denied because the individual is not eligible for coverage under the plan, the coverage determination is part of a claim and must be handled in accordance with the claims procedures of the plan and the requirements of the regulation. See 65 FR at 70255.

---

**A-4: Does the regulation apply to a request for prior approval of a benefit or service when such prior approval is not required under the terms of the plan?**

No. If the plan does not require prior approval for the benefit or service with respect to which the approval is being requested, the request is not a claim for benefits (§ 2560.503-1(e)) governed by the regulation. The regulation defines pre-service claim by reference to the plan's requirements, not the claimant's decision to seek the medical care, nor the doctor's decision to provide care. Thus, in the absence of any plan requirement for prior approval, mere requests for advance information on the plan's possible coverage of items or services or advance approval of covered items or services do not constitute pre-service claims under the regulation. See § 2560.503-1(m)(2).

---

**A-5: Is a plan required to treat all questions regarding benefits as claims for benefits under the plan?**

No. The regulation does not govern casual inquiries about benefits or the circumstances under which benefits might be paid under the terms of a plan. On the other hand, a group health plan that requires the submission of pre-service claims, such as requests for preauthorization, is not entirely free to ignore pre-service inquiries where there is a basis for concluding that the inquirer is attempting to file or further a claim for benefits, although not acting in compliance with the plan's claim filing procedures. In such a case, the regulation requires the plan to inform the individual of his or her failure to



file a claim and the proper procedures to be followed. Specifically, this type of notification is required where there is a communication by a claimant or authorized representative (e.g., attending physician) that is received by a person or organizational unit customarily responsible for handling benefit matters (e.g., personnel office) and that communication names the specific claimant, specific medical condition or symptom and a specific treatment, service, or product for which approval is requested. Under the regulation, notice must be furnished as soon as possible, but not later than 24 hours in the case of urgent care claims or 5 days in the case of non-urgent claims. Notice may be oral, unless a written notification is requested. See § 2560.503-1(c)(1).

---

**A-6: Do the requirements applicable to group health plans apply to dental benefits offered as a stand-alone plan or as part of a group heath plan?**

Yes, in both cases. The regulation defines group health plan as an employee welfare benefit plan within the meaning of ERISA section 3(1) to the extent that such plan provides medical care within the meaning of section 733(a) of ERISA. See § 2560.503-1(m)(6). Section 733(a)(2) defines medical care, in part, to mean the diagnosis, cure, mitigation, treatment, or prevention of disease, or amounts paid for the purpose of affecting any structure or function of the body. Accordingly, for purposes of the claims procedure rules, the provision of dental benefits, either as part of a larger welfare plan, or as a stand-alone plan, would be subject to the requirements of the regulation applicable to group health plans.

---

**A-7: Do the requirements applicable to group health plans apply to prescription drug benefit programs offered as a stand-alone plan or as part of a group health plan?**

Yes, in both cases. Prescription drug benefits would, like dental benefits, constitute medical care within the meaning of Section 733(a)(2). See question A-6. Accordingly, the provision of prescription drug benefits, either as a stand-alone plan, or as part of a group health plan, would be subject to the requirements of the regulation applicable to group health plans. Whether, and under what circumstances, specific practices permitted under the plan, such as the submission of a prescription to a pharmacy or pharmacist, will constitute a claim for benefits governed by the claims procedure rules will depend on the terms of the plan.

---

**A-8: Do the requirements applicable to group health plans apply to contractual disputes between health care providers (e.g., physicians, hospitals) and insurers or managed care organizations (e.g., HMOs)?**

No, provided that the contractual dispute will have no effect on a claimant's right to benefits under a plan. The regulation applies only to claims for benefits. See questions A-3, A-4, A-5. The regulation does not apply to requests by health care providers for payments due them – rather than due the claimant – in accordance with contractual arrangements between the provider and an insurer or managed care organization, where the provider has no recourse against the claimant for amounts, in



whole or in part, not paid by the insurer or managed care organization.

The following example illustrates this principle. Under the terms of a group health plan, participants are required to pay only a $10 co-payment for each office visit to a preferred provider doctor listed by a managed care organization that contracts with such doctors. Under the preferred provider agreement between the doctors and the managed care organization, the doctor has no recourse against a claimant for amounts in excess of the co-payment. Any request by the doctor to the managed care organization for payment or reimbursement for services rendered to a participant is a request made under the contract with the managed care organization, not the group health plan; accordingly, the doctor's request is not a claim for benefits governed by the regulation.

On the other hand, where a claimant may request payments for medical services from a plan, but the medical provider will continue to have recourse against the claimant for amounts unpaid by the plan, the request, whether made by the claimant or by the medical provider (e.g., in the case of an assignment of benefits by the claimant) would constitute a claim for benefits by the claimant. For information on authorized representatives of claimants. See questions B-1, B-2, B-3.

---

**A-9: What benefits are disability benefits subject to the special rules applicable under the regulation for disability claims?**

A benefit is a disability benefit under the regulation, subject to the special rules for disability claims, if the plan

conditions its availability to the claimant upon a showing of disability. It does not matter how the benefit is characterized by the plan or whether the plan as a whole is a pension plan or a welfare plan. If the claims adjudicator must make a determination of disability in order to decide a claim, the claim must be treated as a disability claim for purposes of the regulation. As the department stated in the preamble to the regulation, 65 FR at 70247, n.4, where a single plan provides more than one type of benefit, it is the department's intention that the nature of the benefit should determine which procedural standards apply to a specific claim, rather than the manner in which the plan itself is characterized. Accordingly, plans, including pension plans, that provide benefits conditioned upon a determination of disability must maintain procedures for claims involving such benefits that comply with the requirements of the regulation applicable to disability claims, including the requirements for de novo review, the consultation requirement for medical judgments, the limit on appeal levels, the time limits for deciding disability claims, and the disclosure requirements in connection with extensions of time.

However, if a plan provides a benefit the availability of which is conditioned on a finding of disability, and that finding is made by a party other than the plan for purposes other than making a benefit determination under the plan, then the special rules for disability claims need not be applied to a claim for such benefits. For example, if a pension plan provides that pension benefits shall be paid to a person who has been determined to be disabled by the Social Security Administration or under the employer's long term disability plan, a claim for pension benefits based on the prior determination that the claimant is



disabled would be subject to the regulation's procedural rules for pension claims, not disability claims.

---

**A-10: Do the time frames in these rules govern the time within which claims must be paid?**

No. While the regulation establishes time frames within which claims must be decided, the regulation does not address the periods within which payments that have been granted must be actually paid or services that have been approved must be actually rendered. Failure to provide services or benefit payments within reasonable periods of time following plan approval, however, may present fiduciary responsibility issues under Part 4 of title I of ERISA.

---

**A-11: When a group health plan participant presents a prescription to a pharmacy to be filled at a cost to the participant determined by reference to a formula or schedule established in accordance with the terms of such plan and with respect to which the pharmacy exercises no discretion on behalf of the plan, does the regulation require that the presentation of the prescription be treated as a claim for benefits?**

No. As indicated in question A-7, whether, and under what circumstances, specific practices permitted under a plan, such as the presentation of a prescription to a pharmacy, will constitute a claim for benefits governed by the claims procedure rules will depend on the terms of the plan. In this regard, a claim for benefits is defined in § 2560.503-1(e) to

mean a request for a plan benefit or benefits made by a claimant in accordance with a plan's reasonable procedure for filing benefit claims. Accordingly, whether, and to what extent, the presentation of a prescription to a pharmacy which exercises no discretion on behalf of the plan will constitute a request for a plan benefit will be determined by reference to the plan's procedures for filing benefit claims.

It is not uncommon for group health plans to have arrangements with preferred or network providers (e.g., doctors, physical therapists, pharmacies, optometrists) to provide medical care-related services or products at a predetermined cost to covered plan participants and with respect to which the providers exercise no discretion on behalf of the plan. It is the view of the department that neither the statute nor the claims procedure regulation requires that a plan treat interactions between participants and preferred or network providers under such circumstances as a claim for benefits governed by the regulation. Moreover, if the pharmacy refuses to fill the prescription absent payment of the entire cost by the participant, the regulation does not require that this refusal be treated as an adverse benefit determination under the regulation. It should be noted, however, that where a plan provides such benefits the plan must maintain a reasonable procedure, in accordance with the regulation, for processing claims of participants relating to such benefits.

---



**A-12: Does the regulation apply to benefit claims filed by participants in top hat plans, e.g., plans that are unfunded and maintained primarily for the purpose of providing deferred compensation for a select group of management or highly compensated employees?**

Yes. The regulation establishes requirements for all employee benefit plans that are covered under Part 5 of ERISA, which would include top hat plans. Certain top hat plans are specifically excluded from parts of ERISA (see, e.g., sections 201(2); 301(a)(3); 401(a)(1)), but that exclusion does not apply to section 503, under which the regulation was promulgated. In this regard, paragraph (b)(2) of the regulation requires that a description of the plan's claims procedures must be included as part of the plan's summary plan description meeting the requirements of 29 CFR § 2520.102-3. Where a top hat plan is not required to furnish summary plan descriptions, pursuant to 29 CFR §§ 2520.104-23 or 2520.104-24, such plan may satisfy the requirements of paragraph (b)(2) of the regulation by taking steps reasonably designed to ensure that participants in such plans are made aware of the existence of the plan's claims procedures in conjunction with enrollment in the plan and how to obtain such procedures upon request.

---

**A-13: Would a determination of disability for purposes of receiving a premium waiver under a contributory life insurance plan be governed by the special rules applicable to disability benefits under the claims procedure regulation?**

Yes. A benefit is a disability benefit under the regulation, subject to the special rules for disability claims, if the plan conditions availability of the benefit on a showing of disability. As noted in question A-9, however, if a plan provides a benefit the availability of which is conditioned on a finding of disability, and that finding is made by a party other than the plan for purposes other than making a benefit determination under the plan, then the special rules for disability claims need not be applied to a claim for such benefits. The department notes that the inclusion of a premium waiver in a plan that is not otherwise covered by ERISA would not, in and of itself, cause the plan to become subject to the regulation.

---

**B-1: May a plan require that a claimant complete and file a form identifying any person authorized to act on his or her behalf with respect to a claim?**

Yes, with one exception. The regulation provides that a reasonable claims procedure may not preclude an authorized representative of a claimant from acting on behalf of a claimant with respect to a benefit claim or appeal of an adverse benefit determination. The regulation also provides, however, that a plan may establish reasonable procedures for determining whether an individual has been authorized to act on behalf of the claimant. Completion of a form by the claimant identifying the authorized



representative would be one method for making such a determination.

The one exception is where a claim involves urgent care. In such instances, a plan must, without regard to the plan's procedures for identifying authorized representatives, permit a health care professional with knowledge of the claimant's medical condition (e.g., a treating physician) to act as the authorized representative of the claimant. This exception is intended to enable a health care professional to pursue a claim on behalf of a claimant under circumstances where, for example, the claimant is unable to act on his or her own behalf. See § 2560.503-1(b)(4).

---

**B-2: Does an assignment of benefits by a claimant to a health care provider constitute the designation of an authorized representative?**

No. An assignment of benefits by a claimant is generally limited to assignment of the claimant's right to receive a benefit payment under the terms of the plan. Typically, assignments are not a grant of authority to act on a claimant's behalf in pursuing and appealing a benefit determination under a plan. In addition, the validity of a designation of an authorized representative will depend on whether the designation has been made in accordance with the procedures established by the plan, if any.

---

**B-3: When a claimant has properly authorized a representative to act on his or her behalf, is the plan required to provide benefit determinations and other notifications to the authorized representative, the claimant, or both?**

Nothing in the regulation precludes a plan from communicating with both the claimant and the claimant's authorized representative. However, it is the view of the department that, for purposes of the claims procedure rules, when a claimant clearly designates an authorized representative to act and receive notices on his or her behalf with respect to a claim, the plan should, in the absence of a contrary direction from the claimant, direct all information and notifications to which the claimant is otherwise entitled to the representative authorized to act on the claimant's behalf with respect to that aspect of the claim (e.g., initial determination, request for documents, appeal, etc.). In this regard, it is important that both claimants and plans understand and make clear the extent to which an authorized representative will be acting on behalf of the claimant.

---

**B-4: What kind of administrative processes and safeguards must a plan have in place to ensure and verify appropriately consistent decision making?**

The department did not intend to prescribe any particular process or safeguard to ensure and verify consistent decision making by plans. To the contrary, the department intended to preserve the greatest flexibility possible for designing and operating claims processing systems consistent with the prudent administration of a plan. The



department believes that prudent plan administration requires ensuring that similarly situated claims are, under similar circumstances, decided in a consistent manner. Consistency in the benefit claims determinations might be ensured by applying protocols, guidelines, criteria, rate tables, fee schedules, etc. Consistent decision making might be ensured and verified by periodic examinations, reviews, or audits of benefit claims to determine whether the appropriate protocols, guidelines, criteria, rate tables, fee schedules, etc. were applied in the claims determination process. See § 2560.503-1(b)(5).

---

**B-5: For purposes of furnishing relevant documents to a claimant, what kind of disclosure is required to demonstrate compliance with the administrative processes and safeguards required to ensure and verify appropriately consistent decision making in making the benefit determination?**

What documents will be required to be disclosed will depend on the particular processes and safeguards that a plan has established and maintains to ensure and verify appropriately consistent decision making. See 65 FR at 70252. The department does not anticipate new documents being developed solely to comply with this disclosure requirement. Rather, the department anticipates that claimants who request this disclosure will be provided with what the plan actually used, in the case of the specific claim denial, to satisfy this requirement. The plan could, for example, provide the specific plan rules or guidelines governing the application of specific protocols, criteria, rate tables, fee schedules, etc. to claims like the claim at issue, or the specific checklist or cross-checking

document that served to affirm that the plan rules or guidelines were appropriately applied to the claimant's claim. Plans are not required to disclose other claimants' individual records or information specific to the resolution of other claims in order to comply with this requirement. See § 2560.503-1(m)(8)(iii). See question D-12.

---

**B-6: Do the regulation's limits on the use of pre-dispute arbitration extend to other actions that a participant or beneficiary might pursue with regard to a health care provider or other person or entity?**

No. The regulation is intended to regulate pre-dispute arbitration only with respect to group health and disability benefits provided under ERISA-covered plans. The regulation is not intended to affect the enforceability of a pre-dispute arbitration agreement with respect to any other claims or disputes. Accordingly, the regulation should not be read to affect the obligation of a participant or beneficiary to arbitrate such other claims and disputes within the scope of the arbitration agreement. See 29 CFR § 2560.503-1(c)(3)(iii).

---

**C-1: When does the time period for making an initial decision on a claim begin to run?**

The time for making an initial claims decision begins to run when the claim is filed in accordance with a plan's reasonable filing procedures, regardless of whether the plan has all of the information necessary to decide the claim at the time of the filing.



For purposes of calculating the time period within which a claim must be decided, a plan cannot extend the time period by treating as filed only those claims with respect to which all the information necessary to make a decision has been submitted (often referred to as clean claims). See § 2560.503-1(f)(4).

---

**C-2: May a plan's claims procedures require claimants to submit relevant medical information or information relating to coordination of benefits prior to the plan's making a decision on a claim?**

Plans have considerable flexibility in defining the procedures to be followed for the initiation, processing, and appeal of benefit claims. However, while plans may require the submission of specific information necessary to a benefit determination under the terms of the plan, including medical and coordination of benefit information, the plan may nonetheless have to make a decision on the claim before receiving such information. As noted in question C-1, the time periods applicable to deciding claims begin to run on the date a claim is filed in accordance with reasonable procedures of the plan, without regard to whether all the information necessary to make a benefit determination accompanies the filing. See § 2560.503-1(f)(4).

---

**C-3: If the period within which a group health claim must be decided is ending and the claimant has yet to furnish all the information necessary to decide the claim, may the plan extend the time period for deciding the claim and, if so, for how long?**

In general, a group health plan may unilaterally extend the decision making on both pre-service and post-service claims for 15 days after the expiration of the initial period, if the administrator determines that such an extension is necessary for reasons beyond the control of the plan. There is no provision for extensions in the case of claims involving urgent care.

If the reason for taking the extension is the failure of the claimant to provide information necessary to decide the claim, and the claimant is so notified of this fact, the time period for making the decision is suspended (tolled) from the date of the notification to the claimant to the earlier of:

> The date on which a response from the claimant is received by the plan
>
> The date established by the plan for the furnishing of the requested information (at least 45 days)

The extension period (15 days) – within which a decision must be made by the plan – will begin to run from the date on which the claimant's response is received by the plan (without regard to whether all of the requested information is provided) or, if earlier, the due date established by the plan for furnishing the requested information (at least 45 days). See §§ 2560.503-1(f)(2)(iii) (A) and (B); 2560.503-1(f)(4); 2560.503-1(i)(4). Also see 65 FR at 70250, n.21.

---



**C-4: Many plans, including group health and disability plans, require claimants to submit to examination by an expert or experts of the plan's choosing in connection with the plan's consideration of the claimant's claim. How do the regulation's time limits apply to the completion of such examinations?**

The regulation's time limits begin to run when a claim is filed in accordance with the reasonable procedures of the plan for filing claims. See question C-1. A plan that requires a physical or other examination of the claimant to evaluate a claim must design a process that provides for decision making within the time frames of the regulation.

If necessary, however, in the circumstances of a specific claim, a plan may take an extension of time to enable the claimant to submit requested information (including the report of a required examination). The regulation's provisions on extensions of time and tolling, discussed in question C-3, would apply to these situations to determine when an extension is permitted and when an extension would begin and end. Under those rules, when a plan takes an extension of time because additional information must be obtained from a claimant, the claimant must be provided at least 45 days within which to provide the information or submit to the requested examination. Plans may, of course, provide claimants longer periods of time for this purpose.

---

**C-5: May a claimant agree to an extension or further extension of the time period within which a plan must decide a claim?**

Yes. The only limits on extensions of time established by the regulation are imposed on plans. Claimants may voluntarily agree to provide a plan additional time within which to make a decision on a claim, even under circumstances where the plan could not unilaterally extend the decision making period, such as in the case of a claim involving urgent care or a claim on appeal.

See §§ 2560.503-1(f)(2)(i); 2560.503-1(i). Also see 65 FR at 70250, n.21.

---

**C-6: What responsibility does the plan have for determining whether any specific claim involves urgent care and must therefore be decided on an expedited basis?**

A plan has a duty to make this determination on the basis of the information provided by, or on behalf of, the claimant. A claim involving urgent care is any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the claimant or the claimant's ability to regain maximum function, or – in the opinion of a physician with knowledge of the claimant's medical condition – would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.



In determining whether a claim involves urgent care, the plan must apply the judgment of a prudent layperson who possesses an average knowledge of health and medicine. However, if a physician with knowledge of the claimant's medical condition determines that a claim involves urgent care, the claim must be treated as an urgent care claim. See § 2560.503-1(m)(1).

---

**C-7: Under the regulation, urgent care claims must be decided as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt, and pre-service claims must be decided within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt. Can a plan's claims procedures require claimants to explain or describe whether, and what, medical exigencies or medical circumstances exist?**

Yes. While the department has indicated that the time periods for decision making are generally maximum periods and not automatic entitlements, the department recognizes that assessments of the appropriate timeframe for making benefit determinations will, in large part, be dependent on the information provided by the claimant. Requesting specific information from the claimant regarding whether and what medical circumstances exist that may give rise to a need for expedited processing of the claim would appear to facilitate claims processing and, therefore, would not, in the view of the department, be an unreasonable plan request. If, on the other hand, the plan believes based on its own review of the claim that expedited processing is required, it is the view of the department that

the claim must be processed on an expedited basis without regard to the claimant's failure to provide information relating to whether expedited processing is necessary.

---

**C-8: If a claimant requests a plan to extend a previously approved course of treatment, by either increasing the number of treatments or the period of time for treatments, and that request is determined by the claimant's treating physician to be a claim involving urgent care, within what period must the plan approve or deny the claimant's request?**

Under the concurrent care provisions of the rule, any request that involves both urgent care and the extension of a course of treatment beyond the period of time or number of treatments previously approved by the plan must be decided as soon as possible, taking into account the medical exigencies, and notification must be provided to the claimant within 24 hours after receipt of the claim, when the request is made at least 24 hours prior to the expiration of the prescribed period of time or number of treatments. If such a request is not made at least 24 hours prior to the expiration of the prescribed period of time or number of treatments, the request must be treated as a claim involving urgent care and decided in accordance with the urgent care claim timeframes, i.e., as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt. See § 2560.503-1(f)(2)(i) and (ii) (B).

If a request to extend a course of treatment beyond the period of time or number of treatments previously approved



by the plan does not involve urgent care, the request may be treated as a new benefit claim and decided within the timeframe appropriate to the type of claim, i.e., as a pre-service claim or a post-service claim. § 2560.503-1(f)(2)(iii).

---

**C-9: In the case of a group health plan's decision to reduce or terminate a previously approved course of treatment, must claimants be afforded at least 180 days to appeal the plan's revised determination before the benefit can be reduced or terminated?**

No. Under the concurrent care provisions of the rule, any reduction or termination of a course of treatment (other than by plan amendment) before the end of the previously approved period or number of treatments is treated as an adverse benefit determination. In such cases the rule requires that the plan administrator provide the claimant sufficient advance notice of the reduction or termination to allow the claimant to appeal and obtain a determination before the benefit is reduced or terminated. Generally, claimants must be afforded at least 180 days following an adverse benefit determination to appeal that determination. If the 180 day rule applied to appeals under concurrent care provisions of the regulations, notifications of reductions or terminations would, in every instance, have to be given at least six months in advance of the termination or reduction. This was not the intention of the department. Accordingly, while the department is of the view that plans must afford claimants a reasonable period of time within which to develop their appeal of a proposed reduction or termination, plans are not required to assume that claimants will need the full 180 days to file such an

appeal before the benefit can be reduced or terminated under the special rules governing concurrent care claims. See § 2560.503-1(f)(2)(ii) (A).

---

**C-10: In what circumstances, if any, would a post-service claim be a claim involving urgent care?**

Post-service claims are those claims with respect to which plan approval is not a prerequisite to obtaining medical services and payment is being requested for medical care already rendered to the claimant. Accordingly, a post-service claim would never constitute a claim involving urgent care within the meaning of the regulation.

A post-service claim is defined in the regulation as any claim for a benefit under a group health plan that is not a pre-service claim. Pre-service claims are those claims with respect to which the terms of the plan condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care. See question C-6, § 2560.503-1(m)(1), (2), and (3).

---

**C-11: If a claim is determined to involve urgent care when it is initially filed, must it automatically continue to be treated as urgent if it is denied and the claimant files an appeal, regardless of whether, at that time, medical services have actually been provided and the only question to be resolved is who will pay for such services?**

No. The nature of a claim or a request for review of an adverse benefit determination should be judged as of the



time the claim or review is being processed. If requested services have already been provided between the time the claim was denied and a request for review is filed, the claim no longer involves urgent care because use of the post-service time frames for deciding the appeal could not jeopardize the claimant's life, health, or ability to regain maximum function, or subject the claimant to severe pain. See § 2560.503-1(m)(1).

---

**C-12: If a claimant submits medical bills to a plan for reimbursement or payment, and the plan, applying the plan's limits on co-payment, deductibles, etc., pays less than 100% of the medical bills, must the plan treat its decision as an adverse benefit determination?**

Under the regulation, an adverse benefit determination generally includes any denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit. In any instance where the plan pays less than the total amount of expenses submitted with regard to a claim, while the plan is paying out the benefits to which the claimant is entitled under its terms, the claimant is nonetheless receiving less than full reimbursement of the submitted expenses. Therefore, in order to permit the claimant to challenge the plan's calculation of how much it is required to pay, the decision is treated an adverse benefit determination under the regulation. Providing the claimant with the required notification of adverse benefit determination will give the claimant the information necessary to understand why the plan has not paid the unpaid portion of the expenses and to decide whether to challenge the denial, e.g., the failure to pay in

full. This approach permits claimants to challenge whether, for example, the plan applied the wrong co-payment requirement or deductible amount. The fact that the plan believes that a claimant's appeal will prove to be without merit does not mean that the claimant is not entitled to the procedural protections of the rule. This approach to informing claimants of their benefit entitlements with respect to specific claims, further, is consistent with current practice, in which Explanation of Benefits forms routinely describe both payable and non-payable portions of claim-related expenses. See § 2560.503-1(m)(4).

---

**C-13: Under what circumstances is a plan required to notify a claimant of a benefit determination that is not an adverse benefit determination, i.e., a complete grant of a claim?**

In the case of urgent care claims and pre-service claims, the regulation requires that claimants be apprised of the plan's benefit determination, whether the determination is adverse or a complete grant. The rules require that this notification be furnished in accordance with the time-frames generally applicable to urgent care and pre-service claims. There is no specific notification requirement applicable to post-service claims that are fully granted. See § 2560.503-1(f)(2)(i) and (iii).

---



**C-14: What information is a plan required to provide when giving notice of a claim determination that is not adverse (that has been completely granted), in the case of an urgent care or pre-service claim?**

The regulation does not specify the information that must be provided in notices of benefit determinations that are not adverse. However, in accordance with the regulation's general requirement of reasonableness, the department anticipates that such notices will contain sufficient information to fully apprise the claimant of the plan's decision to approve the requested benefits. See § 2560.503-1(f)(2)(i) and (iii) (A).

---

**C-15: When a plan has approved a benefit that will be provided over a period of time, such as a series of chemotherapy treatments, must the plan notify the claimant when the benefits end?**

No. Provided that the plan complied with the regulation in adequately notifying the claimant regarding the scope of the benefit that was originally approved (e.g., for how long, how many treatments, etc.) and further provided that the plan has not decided to reduce or terminate early the course of treatment that was previously approved, the regulation does not require the plan to provide a formal notification that the course of treatment is coming to an end. See § 2560.503-1(f)(2)(ii).

---

**C-16: May a notice of an adverse benefit determination generally state that a rule, guideline or protocol may have been relied upon in making the benefit determination and satisfy the requirements of the regulation?**

No. The regulation provides that if an internal rule, guideline, protocol, or similar criterion was relied upon in making an adverse benefit determination, the notification of the adverse benefit determination must either set forth the rule, guideline, protocol, or criterion or indicate that such was relied upon and will be provided free of charge to the claimant upon request. It would be sufficient, in the view of the department, in such a case, to indicate that an internal rule, etc., had been relied upon without specifying the identity of the specific rule and that the specific rule, etc. would be furnished to the claimant upon request. A notice that merely indicates, however, that a rule, guideline, protocol, or similar criterion may have been relied upon does not provide the claimant any specific information about the basis on which his or her claim was decided. Inasmuch as plans will know in every instance what rules, protocols, guidelines, etc. were relied upon in making a determination, providing an indication whether such was relied upon should not be difficult. Moreover, the department is concerned that the routine inclusion of such a statement in all adverse benefit determination notifications may undermine the significance of the required disclosure. See § 2560.503-1(g)(1)(v) (A). For similar reasons, a general statement in an adverse benefit determination notice would not be considered as satisfying the requirements of § 2560.503-1(g)(1)(v) (B). Also see § 2560.503-1(j)(5)(i) and (ii).

---



**C-17: Is a plan required to provide a copy of an internal rule, guideline, protocol, or similar criterion when the applicable rule, guideline, protocol, or criterion was developed by a third party which, for proprietary reasons, limits the disclosure of that information?**

Yes. It is the view of the department that where a rule, guideline, protocol, or similar criterion serves as a basis for making a benefit determination, either at the initial level or upon review, the rule, guideline, protocol, or criterion must be set forth in the notice of adverse benefit determination or, following disclosure of reliance and availability, provided to the claimant upon request. However, the underlying data or information used to develop any such rule, guideline, protocol, or similar criterion would not be required to be provided in order to satisfy this requirement. The department also has taken the position that internal rules, guidelines, protocols, or similar criteria would constitute instruments under which a plan is established or operated within the meaning of section 104(b)(4) of ERISA and, as such, must be disclosed to participants and beneficiaries. See §§ 2560.503-1(g)(v)(A) and (j)(5)(i); 65 FR at 70251. Also see §§ 2560.503-1(h)(2)(iii) and 2560.503-1(m)(8)(i); Advisory Opinion 96-14A (July 31, 1996).

---

**C-18: If a plan conditions continuation of disability benefit payments on a periodic confirmation of the claimant's disability and, in conjunction with such a confirmation, determines that the claimant is no longer disabled and, accordingly, terminates payment of benefits, must the plan treat the termination as an adverse benefit determination under the regulation?**

Yes. Under the regulation, an adverse benefit determination includes any denial, reduction, or termination of a benefit. Accordingly, where a plan terminates the payment of disability benefits under such circumstances, the plan is required to provide the claimant a notification of adverse benefit determination and the right to appeal that determination consistent with the regulation. See 29 CFR § 2560.503-1(m)(4), (g) and (h). If, on the other hand, a plan provides for the payment of disability benefits for a pre-determined, fixed period (e.g., a specified number of weeks or months or until a specified date), the termination of benefits at the end of the specified period would not constitute an adverse benefit determination under the regulation. Any request by a claimant for payment of disability benefits beyond the specified period, therefore, would constitute a new claim. See 29 CFR § 2560.503-1(f)(3). Also see 29 CFR § 2560.503-1(f)(2)(ii).

---

**C-19: Does the regulation limit a plan's ability to establish a maximum period for the filing of initial claims for benefits?**

No. The regulation does not contain any specific rules governing the period of time that must be given to claimants



to file their claims. However, a plan's claim procedure nonetheless must be reasonable and not contain any provision, or be administered in any way, that unduly inhibits or hampers the initiation or processing of claims for benefits. Adoption of a period of time for filing claims that serves to unduly limit claimants' reasonable, good faith efforts to make claims for and obtain benefits under the plan would violate this requirement. See 29 CFR § 2560.503-1(b)(3).

---

**C-20: What timeframes apply when an extension of time is required by a plan in connection with an initial disability benefit determination?**

The regulation addresses two situations in which a plan may have an extension of time for making a disability benefit determination. The first situation is when a decision cannot be rendered due to any matter beyond the control of the administrator other than the need for additional information from the claimant. In this situation, the extension period is added to the period within which the determination is required to be made. For example, if prior to the end of the initial 45-day period, the administrator determines that, for reasons beyond its control, a decision cannot be rendered, the plan may take up to an additional 30 days (i.e., 30 days in addition to the initial 45-day period). Similarly, if a decision cannot, for similar reasons, be rendered within the initial extension period, the plan may take up to an additional 30 days (i.e., 30 days in addition to the initial 30-day extension period) or up to a total of 105 days to decide the pending claim. See 29 CFR § 2560.503-1(f)(3). The second situation is when the plan requires additional information from the

claimant to make a benefit determination. This situation is governed by the principles in question C-3.

---

**C-21: If a plan determines that a claim does not provide sufficient information, must the plan take an extension of time and request additional information from the claimant?**

No. The provisions governing extensions of time are permissive and not mandatory. As such, plans may provide for taking extensions of time or not, and plan administrators may be given the discretion to decide whether to take an extension of time in connection with any individual claim. Consequently, as a general matter, a plan may deny claims at any point in the administrative process on the basis that it does not have sufficient information; such a decision would allow the claimant to advance to the next stage of the claims process.

---

**C-22: If a group health plan determines that an extension of time is necessary in order to obtain additional information from a claimant, may the administrator as part of the notice to the claimant of the need for the extension of time also include a notice of adverse benefit determination applicable if the claimant fails to provide any information within the period prescribed by the plan (i.e., at least 45 days)?**

Yes. If the notice clearly states that the claim will be denied if the claimant fails to submit any information in response to the plan's request, it is the view of the department that the



furnishing of a combined notice would not be contrary to the regulation, provided that the combined notice satisfied the content requirements applicable to both the extension notice and the notice of adverse benefit determination. In this regard, the notice of adverse benefit determination should make clear that the period for appealing the denied claim begins to run at the end of the period prescribed in the notice for submitting the requested information (or such later date as may be provided under the terms of the plan). See 29 CFR § 2560.503-1(f)(2) and (3).

---

**D-1: May a plan require that requests for review of adverse benefit determinations be made in writing?**

Yes, with one exception. The regulation provides that a plan's claims procedure must provide a claimant with a reasonable opportunity for a full and fair review of a denied claim. A claims procedure that requires requests for reviews of adverse benefit determinations to be made in writing would not be unreasonable in that regard, except with respect to claims involving urgent care. In the case of urgent care claims, the regulation requires that a plan's procedures permit requests for expedited appeals to be submitted orally or in writing by the claimant. See § 2560.503-1(h)(2) and (3)(vi).

---

**D-2: May the direct supervisor of the person(s) who makes initial claim determinations serve as the appropriate named fiduciary for purposes of reviewing those claims on appeal?**

Yes. The only limitation that the rule imposes on who can serve as the named fiduciary for purposes of reviewing adverse benefit determinations is that the named fiduciary cannot be either the individual who made the initial benefit determination that is the subject of the appeal or a subordinate of that individual. The rule further requires that the reviewer, whoever that individual is, may not afford deference to the initial determination. That is, the reviewer must consider the full record of the claim and make an independent decision on whether it should be granted. See § 2560.503-1(h)(3)(ii).

---

**D-3: If a group health plan provides for two levels of review, rather than one, following an adverse benefit determination, what standards, if any, govern the second level of review?**

Where a plan provides for two levels of review on appeal, it is the view of the department that the second level of review is subject to the same standards that apply to the first level of review. For example, the second-level reviewer may not afford deference to the decision at the first level of review, and the reviewer must not be the same person who made the first level review decision on the claim or a subordinate of that person. See §§ 2560.503-1(c)(2) and 2560.503-1(h)(3)(ii).

---



**D-4: If a group health plan provides for two levels of review following an adverse benefit determination, within what period must a determination be made at each level?**

In the case of pre-service claims, a maximum of 15 days is provided for a benefit determination at each level. In the case of post-service claims, a maximum of 30 days is provided for a determination at each level. See § 2560.503-1(i)(2)(ii) and (iii).

For example, if a claimant appeals a pre-service adverse benefit determination, and the plan provides for two levels of review at the appeal level, the plan must make a determination within a reasonable period of time, taking into account the medical circumstances, but no later than 15 days after receipt of the appeal. If that claim is again denied at the first level of appeal and the claimant appeals that denial to the second level review stage, the plan must again make a determination within a reasonable period of time, taking into account the medical circumstances, but not later than 15 days after the plan's receipt of the claimant's second level appeal request.

In the case of urgent care claims, the regulation does not prescribe any specific period within which a determination must be made at each level of a two-level review process for such claims. Given the principles underlying the provisions governing pre- and post-service claims, however, it is the view of the department that each level of review of an urgent care claim would have to be completed in sufficient time to ensure that the total period for completing the reviews would not exceed the maximum period otherwise applicable to a process with only one level of review – as soon as possible, taking into account the

medical exigencies, but not longer than 72 hours. See § 2560.503-1(i)(2)(i).

---

**D-5: If a group health plan provides for two levels of review following an adverse benefit determination, how much time must a claimant be afforded to appeal the first level review determination to the second level review?**

Under the regulation, claimants must be afforded at least 180 days following receipt of an adverse benefit determination to appeal that determination. In the case of a plan with a two-level review process, the 180-day rule applies to the period to be afforded claimants to appeal to the first review level. While the regulation does not specifically address the period of time to be afforded claimants to pursue the second level of review, the regulation requires that a plan's procedures must nonetheless be reasonable and, therefore, it is the view of the department that plans must afford claimants a reasonable opportunity to pursue a full and fair review at the second review level. See § 2560.503-1(h)(1) and (3)(i).

---

**D-6: If a group health plan provides for two levels of review following an adverse benefit determination, may the plan use non-binding arbitration as a means for deciding the appealed claim?**

Yes. A plan's procedures may provide for arbitration of benefit disputes at one of the two levels of appeal, provided two conditions are met. First, the arbitration must be conducted in a manner that will ensure that the timeframes



and notice requirements otherwise applicable to appeals will be satisfied. Second, the arbitration must be non-binding – that is, the arbitration may not limit the claimant's ability to challenge the benefit determination in court. See § 2560.503-1(c)(4). The regulation also permits a plan to offer binding arbitration to a claimant after completion of the plan's appeal process. See questions E-1 and E-2.

---

**D-7: May the board of trustees or committee of a multi-employer group health plan or multi-employer disability benefit plan that generally reviews appealed benefit claims at their quarterly meetings provide for two levels of appeal consistent with the regulation?**

Yes, under limited circumstances. In general, the regulation permits plans to maintain two levels of review for adverse benefit determinations and establishes special timing rules for making benefit decisions at each level of the review process. See §§ 2560.503-1(c)(2), 2560.503-1(i)(2)(ii) and (iii), 2560.503-1(i)(3). The regulation also provides special timing rules applicable to boards of trustees or committees of multi-employer group health plans and multi-employer disability benefit plans, pursuant to which such plans are excepted from the otherwise applicable timing requirements. Under these rules, such boards or committees generally are permitted to defer the decisions on adverse benefit determination appeals until the next regularly scheduled meeting of the plan's board or committee. See §§ 2560.503-1(i)(2)(iii) (B), 2560.503-1(i)(3)(ii). It is the view of the department that a multi-employer group health plan or a disability benefit plan

could not, in a manner consistent with the regulation, rely on both the special rules governing the maintenance of two appeal levels and the special rules for regularly scheduled boards of trustees or committee meetings. On the other hand, the department does not believe a multi-employer plan is foreclosed by the regulation from electing to make appeal determinations in accordance with the special rules governing two levels of appeal, rather than in accordance with the quarterly meeting provisions of the regulation. In addition, there is nothing in the regulation that would foreclose a multi-employer plan from making benefit review determinations in accordance with the quarterly meeting provisions and, following such determinations, providing claimants with an opportunity to voluntarily pursue an additional (second) review of their claim. See § 2560.503-1(c)(3).

---

**D-8: Does the regulation's requirement of consultation with appropriate health care professionals limit the discretion of a plan fiduciary reviewing an adverse benefit determination with respect to the advice the fiduciary may seek in resolving the issues raised by the review?**

The regulation requires, for group health and disability claims, that the fiduciary deciding an appeal of an adverse benefit determination based in whole or in part on a medical judgment consult with an appropriate health care professional. This requirement of consultation is intended to ensure that the fiduciary deciding a claim involving medical issues is adequately informed as to those issues. The consultation requirement, however, is not intended to constrain the fiduciary from consulting any other experts



the fiduciary considers appropriate under the circumstances. For example, in connection with the appeal of a denied disability claim, a fiduciary may consider it appropriate to consult with vocational or occupational experts. In all cases, a fiduciary must take appropriate steps to resolve the appeal in a prudent manner, including acquiring necessary information and advice, weighing the advice and information so obtained, and making an independent decision on the appeal. The regulation's provision for consultation with a health care professional is not intended to alter the fiduciary standards that apply to claims adjudication.

---

**D-9: Under what circumstances must a group health plan (or disability benefit plan) disclose the identity of experts consulted in the course of deciding a benefit claim?**

The regulation provides that, in order to allow claimants a reasonable opportunity for a full and fair review of their claim, a plan's claims procedures must provide for the identification of medical (or vocational) experts whose advice was obtained on behalf of the plan in connection with an adverse benefit determination, without regard to whether the advice was relied upon in making the determination. Under the rules, plans are not required to automatically provide, as part of a notice of an adverse benefit determination or otherwise, the identity of experts consulted during the claim determination process. Nor are plans required to disclose the name of experts in the absence of an adverse benefit determination. On the other hand, consistent with the procedural requirements of the regulation, the plan must provide the identity of any such

experts when requested by a claimant in connection with an adverse benefit determination. See § 2560.503-1(h)(3)(iv) and (4).

---

**D-10: Upon receipt of a request from a claimant for the identity of experts consulted by the plan in connection with an adverse benefit determination, may a plan satisfy the requirements of the regulation by providing only the name of the company employing the expert or the qualifications of the expert, rather than the name of the expert?**

No. The regulation expressly requires that plans provide for the identification of the medical or vocational expert or experts whose advice was obtained on behalf of the plan in connection with the claimant's claim. Consequently, merely providing the name of the company employing the expert or the qualifications of the expert would not, in the department's view, satisfy this requirement of the regulation. See § 2560.503-1(h)(3)(iv) and (4). See question D-7.

---

**D-11: Does the regulation require that a group health plan provide a claimant with copies of the claimant's medical records relating to his or her benefit claim?**

Yes. The regulation requires a plan to provide claimants, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to a claimant's claim for benefits. Under the regulation, relevant documents include, among other things, documents or records relied upon in making a



benefit determination and documents and records submitted in the course of making the benefit determination. Inasmuch as a claimant's medical records relating to the benefit claim would be relevant documents, access to, and copies of, the claimant's medical records would have to be provided upon the claimant's request. The department notes, however, that if a plan has reason to believe that a claimant's medical records contain information that should be explained or disclosed by the physician (or other health professional) who developed the information, it would not be inconsistent with the regulation to refer the claimant to the physician (or other health professional) for such information prior to providing the requested documents directly to the claimant. However, if the physician to whom the claimant was referred failed to provide the requested information to the claimant in a reasonable period of time and without charge, the plan itself would be required to honor the claimant's request.

---

**D-12: Does the regulation require that a plan provide claimants with access to or copies of files of other claimants?**

No. The regulation requires that a claimant, have access to, and copies of, documents, records and other information relevant to the claimant's claim. For this purpose, the regulation defines as relevant any document, record, or other information that: (i) was relied upon in making the benefit determination; (ii) was submitted, considered, or generated in the course of making the benefit determination, without regard to whether it was relied upon; (iii) demonstrates compliance with the plan's administrative processes and safeguards for ensuring consistent decision

making; or (iv) constitutes a statement of policy or guidance with respect to the group health plan concerning the denied treatment option or benefit for the claimant's diagnosis, without regard to whether it was relied upon in making the benefit determination. See §§ 2560.503-1(h)(2)(iii) and 2560.503-1(m)(8).

While information and data from various claimants' files may have been compiled for purposes of developing a plan's criteria, standards, guidelines, or policies to be used in ensuring and demonstrating compliance with administrative processes and safeguards relating to consistent decision making, (see question B-5); or evaluating or assessing treatment options for benefit determinations, only the criteria, standards, guidelines, or policies themselves would have to be disclosed as information relevant to an individual claimant's claim, not the various claimants' files on which such criteria, standards, guidelines, or policies were based.

---

**D-13: Must a plan include, in every notice of adverse benefit determination on review, a statement apprising claimants that – You or your plan may have other voluntary dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. department of Labor Office and your state insurance regulatory agency?**

The regulation, at § 2560.503-1(j)(5)(iii), provides for the inclusion of the statement described above in all notices of adverse benefit determination on review involving group health and disability claims. However, the department



recognizes that information on the specific voluntary appeal procedures offered by the plan will be provided, consistent with § 2560.503-1(j)(4), in the notice of adverse benefit determination, along with a statement of the claimant's right to bring a civil action under section 502(a) of ERISA. Pending further review, therefore, the department will not seek to enforce compliance with the requirements of § 2560.503-1(j)(5)(iii).

---

**E-1: Under what circumstances may a plan afford claimants the ability to appeal their benefit claim beyond the review level required by the regulation?**

While the regulation limits a plan's claims procedure to a maximum of two mandatory appeal levels, the regulation does permit plans to offer voluntary additional levels of appeal, including arbitration or any other form of alternative dispute resolution, provided that certain conditions are met. The conditions of the regulation focus on ensuring that the claimant elects the additional appeal voluntarily. Specifically, the regulation provides that, in the case of such voluntary levels of appeal, the plan's claims procedure must provide:

> The plan will not assert a failure to exhaust administrative remedies where a claimant elects to pursue a claim in court rather than through the voluntary level of appeal
>
> The plan agrees that any statute of limitations applicable to pursuing the claimant's claim in court will be tolled during the period of the voluntary appeal process

The voluntary level of appeal is available only after the claimant has pursued the appeal(s) required by the regulation

The plan provides the claimant with sufficient information to make an informed judgment about whether to submit a claim through the voluntary appeal process, including the specific information delineated in the regulation

No fees or costs are imposed on the claimant as part of the voluntary appeal process. See § 2560.503-1(c)(3)

---

**E-2: Can a plan's voluntary level of appeal include binding arbitration as a form of benefit dispute resolution?**

Yes. Provided that a plan's claims procedure otherwise complies with the conditions of the regulation applicable to voluntary levels of appeal, there is nothing in the regulation that would preclude a plan from using binding arbitration or any other method of dispute resolution. See § 2560.503-1(c)(3). Also see 65 FR at 70253.

---

**E-3: Do the regulation's special rules on voluntary additional levels of appeal, including arbitration, apply to pension plans or welfare plans other than group health plans or plans providing disability benefits?**

No. The special rules on post-appeal level reviews apply, under the regulation, only to group health plans and plans that provide disability benefits. All other ERISA-covered



plans are not required by the regulation to comply with these rules. However, if such other plans elect to establish voluntary additional levels of review, those levels would have to comport with the general requirements for a reasonable procedure described in § 2560.503-1(b).

---

**F-1: What are the effective date and applicability dates of the new claims procedure rules?**

The regulation became effective as of January 20, 2001. The effective date is the date the regulations became legally effective as part of the Code of Federal Regulations.

The applicability dates are the dates on which plans must begin to comply with the regulation. The applicability date for claims other than group health claims is January 1, 2002. This means that such plans must comply with the regulation beginning with new claims filed on or after January 1, 2002.

As amended on July 9, 2001, the regulation contains separate applicability dates for group health claims and all other claims. Under the regulation as amended on July 9, 2001, the applicability date for group health claims is the first day of the first plan year that begins on or after July 1, 2002, but not later than January 1, 2003. This means that group health plans must comply with the regulation beginning with new claims filed on or after the first day of the first plan year beginning on or after July 1, 2002, but not later than January 1, 2003. For all calendar year group health plans, the applicability date will be January 1, 2003.

Claims that were filed under a plan before the relevant applicability date, and that have not yet been resolved as of the applicability date, may be handled in accordance with the plan's old benefit claims procedures, or, if the plan so chooses, in accordance with the new procedures.

---

**F-2: What principles are likely to be applied when a claimant elects to abandon the plan's administrative claims process in favor of pursuing his or her benefit claim in court?**

Section 503 of ERISA requires plans to set up procedures to provide a full and fair review of denied benefit claims. With limited exceptions, claimants must exhaust those internal procedures before filing a civil action for benefits under section 502(a)(1)(B). This requirement reflects a legal presumption favoring exhaustion of internal procedures.

Paragraph (l) of § 2560.503-1 provides that where a plan fails to establish or follow claims procedures consistent with the requirements of the regulation, a claimant shall be deemed to have exhausted the administrative remedies available under the plan. The claimant shall be entitled to pursue any available remedies under section 502(a) on the basis that the plan has failed to provide a reasonable claims procedure that would yield a decision on the merits.

However, the regulation does not undermine the principle that claimants bear the burden of proving to the satisfaction of the court that the plan failed to establish or follow claims procedures consistent with the requirements of the regulation. In addition, many of the requirements in the regulation give a plan significant discretion in establishing



and following reasonable procedures. For example, paragraph (b)(3) of the regulation prohibits a plan from establishing or administering its procedures so as to unduly inhibit or hamper the initiation or processing of claims for benefits. Accordingly, a plan will be accorded significant deference in evaluating whether it failed to follow a procedure consistent with those aspects of the regulation.

Moreover, not every deviation by a plan from the requirements of the regulation justifies proceeding directly to court. A plan that establishes procedures in full conformity with the regulation might, in processing a particular claim, inadvertently deviate from its procedures. If the plan's procedures provide an opportunity to effectively remedy the inadvertent deviation without prejudice to the claimant, through the internal appeal process or otherwise, then there ordinarily will not have been a failure to establish or follow reasonable procedures as contemplated by § 2560.503-1(l). Thus, for example, a plan that issues a notice of adverse benefit determination fully advising the claimant of the right to review and to request additional information from the plan may be able to correct an inadvertent failure to include in the notice the specific plan provision on which the denial was based. Ordinarily in that circumstance the plan will have provided access to a reasonable claims procedure consistent with the regulations. On the other hand, systematic deviations from the plan procedures, or deviations not susceptible to meaningful correction through plan procedures, such as the failure to include a description of the plan's review procedures in a notice of an adverse benefit determination, would justify a court determination that the plan failed to provide a reasonable procedure.

In addition, filing a lawsuit without exhausting plan procedures could limit claimants' appeal rights and cause claimants to lose benefits to which they otherwise might be entitled. This could be the case when, during the time it takes for a court to dismiss the claimant's suit, the plan's deadline for filing an appeal expires. In this regard, there is nothing in the regulation that would serve to toll internal plan deadlines for filing or appealing claims when suit is brought under section 502(a)(1)(B).

---



**MetLife**

September 15, 1998

5950 Airport Road
PO Box 6146
Utica, New York 13504

Law Offices of
Lawrence D. Rohlfing
12631 East Imperial
Highway, Suite C-115
Santa Fe Springs, CA
90670

RE: Long Term Disability
Claim No: 679801078347
Group No: 36663
SS No: 502-58-1030
Claimant: Kenneth Nord

Dear Mr. Rohlfing

This will supplement our August 7, 1998 correspondence.

To date, we have not received the information we requested in our August 7, 1998 letter. Please be advised we will hold Mr. Nord's claim open an additional 30 days awaiting this information. At that time, his claim will be reviewed based on the information in our possession. You will then be notified of our decision.

Yours Truly,

/s/ Kim Ferguson
Kim Ferguson
Senior Case Management Specialist
Met DisAbility
(800) 300-4296

---

**MetLife**

5950 Airport Road
PO Box 6146
Utica, New York 13504

August 7, 1998

Law Offices of
Lawrence D. Rohlfing
12631 East Imperial
Highway, Suite C-115
Santa Fe Springs, CA
90670

RE: Long Term Disability
Claim No: 679801078347
Group No: 36663
SS No: 502-58-1030
Claimant: Kenneth Nord

Dear Mr. Rohlfing

We are writing in reference to Mr. Nord's Long Term Disability that is currently under review.

We are continuing to review this claim and find that we need an additional 60 days to complete the review under the Employee Retirement Income Security Act of 1974 (ERISA).

As you know, that as part of our review process, Mr. Nord attended a independent medical examination on July 17, 1998. We have enclosed a copy for your review.

It is our impression based upon the report that the Mr. Nord could return to his own sedentary occupation as he does not have physical restrictions that should prevent this.

In order to provide Mr. Nord with a full and fair review, we are requesting you provide his attending physician with a copy of this report. We ask that if the doctor disagrees with our assessment, to please explain by providing or referencing specific clinical/objective medical evidence



that will help support his position and limitations that the Mr. Nord is totally disabled and unable to perform his occupation. If the doctor is in agreement with our assessment, please have him sign and date this notice for our record.

Your time, consideration and continued patience in this matter is greatly appreciated. If you have any questions or concerns with regard to this matter, please do not hesitate to contact our office.

Sincerely,

/s/ Kim Ferguson
Kim Ferguson
Senior Case Management Specialist
Met DisAbility
(800) 300-4296

WINSTON & STRAWN
LEE T. PATERSON (STATE BAR NO. 41004)
AMANDA C. SOMMERFELD (STATE BAR NO. 185052)
444 S. Flower Street
Los Angeles, CA 90071-2911
213-615-1700

Attorneys for Defendant
The Black & Decker Disability Plan

UNITED STATES DISTRICT COURT

CENTRAL DISTRICT OF CALIFORNIA

| | |
|---|---|
| Kenneth L. Nord<br>Plaintiff,<br>vs.<br>The Black & Decker Disability Plan<br>Defendant. | Case No.<br>CV 99-0408 CM (CTx)<br>**DECLARATION OF RAYMOND J. BRUSCA**<br>Date: February 28, 2000<br>Time: 9:00 a.m. |

I, Raymond J. Brusca, declare as follows:

1. I am the Vice President of Benefits for The Black & Decker Corporation and I am designated as the Plan Manager for The Black & Decker Disability Plan (the "Plan.") I have personal knowledge of the facts set forth below and if called as a witness, I could and would testify competently thereto.

2. Kenneth Nord is a former employee of Kwikset Corporation, a wholly-owned subsidiary of The Black & Decker Corporation.



3. As a Material Planner at Kwikset, Mr. Nord controlled inventory levels, ordered goods and interacted with vendors.

4. Kwikset employees are eligible to participate in The Black & Decker Disability Plan, which is administered and funded by Black & Decker entities.

5. On or about July 15, 1997, Mr. Nord ceased working due to a back injury and submitted a claim for long term disability benefits under the Plan.

6. A true and correct copy of the Summary Plan Description pertaining to the Plan that was in effect in 1997 is attached hereto as Exhibit A.

7. A true and correct copy of the Plan Document that was in effect in 1997 is attached hereto as Exhibit B.

8. Attached hereto as Exhibit C is a true and correct copy of the Benefits file pertaining to Kenneth Nord, as of October 27, 1998.

9. The file contains all of the information that was given to my office from Metropolitan Life Insurance Company ("MetLife"), located in Utica, New York.

10. During the time period that is relevant to this action, the Plan Manager delegated claims administration to MetLife, as permitted by the Plan.

11. (a) At that time, MetLife was required to make an initial determination of eligibility for benefits and communicate that conclusion to the claimant, with information on how to submit additional information and seek review of that decision with MetLife's Group Claims Review.

(b) When requested by the claimant, MetLife conducted a review of that decision, and communicated the results to my office.

(c) My office considered MetLife's recommendation and the information in the file at that time. If we agreed with that recommendation, we communicated the results of that internal MetLife review to the claimant, with a notice of his appeal rights under ERISA.

12. This is the process that occurred with respect to Mr. Nord's claim.

13. MetLife initially denied Mr. Nord's claim on February 16, 1998. Its letter to Mr. Nord informed him of the process by which he could have MetLife informally review that determination.

14. Mr. Nord requested a review with MetLife's Group Claims Review.

15. MetLife sent me a letter dated October 15, 1998, in which it explained that its conclusion was that Mr. Nord's claim was properly denied. The letter enclosed "all of the information considered."

16. On October 21, 1998, MetLife sent me another letter, enclosing an October 14, 1998 letter from Mr. Nord's attorney and a "Work Capacity Evaluation" form that had been completed by Kwikset's Human Resources' Representative, Janmarie Forward. MetLife's letter stated that its decision was unchanged, even considering this latest information.

17. Upon receiving the second letter and the Work Capacity Evaluation, I telephoned Janmarie Forward to discuss the document with her. We discussed the specific



duties that were required of Mr. Nord in his position as a Material Planner and his freedom of movement in that position, which was essentially a desk job. He was able to sit or stand at will, and should he have needed any help lifting any items, help was available for him.

18. The Work Capacity Evaluation made no reference to Mr. Nord's tolerance of the pain or ability to do his job with medication.

19. After reviewing the documentation forwarded to me by MetLife and after my conversation with Ms. Forward concerning her responses in the Work Capacity Evaluation and Mr. Nord's particular job responsibilities, I concluded that MetLife's conclusion that benefits were properly denied was correct: Mr. Nord had not shown his "complete inability" to "engage in his regular occupation," as disability is defined by the Plan.

20. Consequently, I directed Jacquelene Redmond to send a letter dated October 27, 1998 to Mr. Nord, confirming the denial of his claim and informing him of his rights to appeal under ERISA. A true and correct copy of that letter is attached hereto as Exhibit D.

21. Mr. Nord did not appeal as outlined in the October 27, 1998 letter.

22. Had Mr. Nord appealed as explained in that letter, the denial would have received a review by the Claims Appeal Committee in Towson, Maryland. At that time, the Claims Appeal Committee consisted of myself and five other persons.

23. On February 24, 1998, I informed Kwikset's Human Resources Director, Loren Meigide, that Mr. Nord's claim for long term disability benefits had been

denied by MetLife. A true and correct copy of this e-mail to Mr. Meigide is attached hereto as Exhibit E.

24. Under Kwikset's policy, when an employee is no longer on an approved leave, he or she must either return to work or be terminated. I sent this notice to Kwikset as a matter of routine practice.

25. MetLife had no role whatsoever in employment decisions, and never advised myself or the Company to terminate anyone's employment, including Mr. Nord's.

26. The e-mails attached hereto as Exhibit F are intercompany e-mails among personnel at Kwikset and/or Black & Decker. None of these communications are communications to or from MetLife.

27. The Plan provides for the calculation of benefits at Sections 2.02 and at Article VI and Article VII. The monthly long term disability benefit is based on the claimant's regular earnings immediately preceding the period of disability and is integrated with social security benefits and any disability benefits provided by state or federal law.

28. Had Mr. Nord's claim been granted, the calculation of his monthly benefit is as follows:

Annual Base Salary ($41,496) X LTD Rate (70%) ÷ 12 = Gross Monthly Benefit ($2,420.60).

The Plan offsets the gross monthly benefit by the estimated monthly entitlement to Social Security benefits (under Section 7.02(A)(1)), which is $1238 per month, leaving a net monthly benefit of $1,182.60. Mr. Nord was paid six months of Salary Continuance, which commenced when he went out on leave in July 1997. His monthly



benefit for his seventh through thirtieth month of disability would have been $1,182 per month, pursuant to Section 6.03(B). In addition, if Plaintiff received state disability benefits from the state of California, that amount must be offset as well, pursuant to Section 7.02(A)(4).

29. Beginning with the 31st month of disability, the Plan provides a new definition of disability: under Section 6.01, benefits continue only for claimants who are disabled from any gainful occupation for which they are reasonably qualified.

30. In addition benefits cease after 30 months for any disability that it attributable to neuromusculoskeletal or soft tissue disorders, under Section 6.04(H) of the Plan.

31. Because Mr. Nord's claim was denied under the "own occupation" definition of disability, the Plan never reached the issues that come into consideration after the 30th month of disability.

I declare under penalty of perjury of the United States of America that the forgoing is true and correct and that this declaration was executed on February 4th, 2000, at Towson, Maryland.

/s/ Raymond J. Brusca
Raymond J. Brusca

[Exhibits Are Bound Separately As A Lodging]

---